



State Title V Block Grant Narrative

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Sections 5.4 – 5.7, containing standard forms and detailed descriptions of national and State performance and outcome measures, are not included in this PDF. Data from these sections can be viewed in interactive formats on the Title V Information System Web site (<http://www.mchdata.net>).

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NEW JERSEY
2001 APPLICATION/ANNUAL REPORT
MATERNAL AND CHILD HEALTH SERVICES
TITLE V BLOCK GRANT PROGRAM
JULY 2000

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I. COMMON REQUIREMENTS FOR APPLICATION AND ANNUAL REPORT

1.1 Letter of Transmittal

1.2 Face Sheet

1.3 Table of Contents

1.4 Overview of the State

A brief overview of New Jersey is included to provide a background of the Title V health needs of the entire State. New Jersey is a geographically small, but densely populated state. Nearly eight million people make it the ninth largest state, with approximately three percent of the total national population. According to 1998 estimates from the US Census Bureau, New Jersey is the most densely populated state, with 1,094 persons per square mile. The State's population is projected to grow steadily, but slowly, through the year 2010 to just over 8.5 million. New Jersey is the most urbanized State, but has no single very large city. Only three municipalities have more than 100,000 residents.

Compared to the nation as a whole, New Jersey is more racially and ethnically diverse. In 1997, 79.9% of the population was white, 14.5% was black, and 5.3% was Asian or Pacific Islander. In terms of ethnicity, 11.9% of the population was Hispanic. New Jersey's racial, national and ethnic mix is also evolving, with its white majority projected to decline by the year 2025 to about 55% of the total population. The percentage of blacks is expected to increase to about 15% by the year 2025. By the year 2025, Hispanics will become the largest minority group, with an estimated increase to just under 20% of total population. Asians, which have become New Jersey's fastest-growing national population sector, are expected to double their existing percentage of the population to approximately 10% by the year 2025. New Jersey's population is also older than the national average, with 13.7% of the population over age 65, compared to 12.7% for the nation as a whole.

The racial and ethnic mix for New Jersey mothers, infants, and children is slightly more diverse than the overall population composition. In 1997, 17.5% of mothers delivering infants in

New Jersey were Hispanic, 73% were white, 18.6% were black, and 6.4% were Asian or Pacific Islanders. The growing diversity of New Jersey's MCH population raises the importance of addressing disparities in health outcomes and improving services to individuals with diverse backgrounds.

ECONOMIC

New Jersey is one of the most affluent states, ranking among the top three states in 1997 in income per capita, per household and per family. In 1997, New Jersey's per capita personal income ranked third in the United States, 27% higher than the national average. As a result, the percentage of New Jersey's population living in poverty is much lower than the national average. In 1997, 9.3% of New Jersey residents had incomes below the Federal Poverty Level, compared to 13.3% nationally. Fewer New Jersey school-aged children live in poverty (15.3%) than those nationally (18.8%).

New Jersey's advantage in average income is offset to some extent by the relatively higher costs of living in its region, which also have averaged among the highest in the nation. During the 1990's, New Jersey's advantage in higher income levels, as well as its disadvantage in higher costs of living, have tended to move it closer to the national income average, as faster-growing states, particularly in the sunbelt, have experienced higher growth rates in income coupled with higher inflation rates increasing their cost of living.

Despite its overall average high-income levels, the State has sharp differences in wealth by region and community with some of the Nation's wealthiest and poorest communities located in close proximity. Development patterns since the end of World War II have been marked by the relocation of upper and middle-income residents to suburban areas, leaving higher proportions of poorer residents in the cities and in small rural communities. The more affluent counties, such as Morris, Somerset, Hunterdon, and Bergen, are in the northern and north central parts of the state. Less affluent counties, such as Cumberland, Cape May and Salem, are located in the southern part of the state. Somerset County, the county with the highest per capita personal income in 1996 of \$44,760, had over twice the income level of \$20,987 recorded in

Cumberland County, the lowest-income county. Fast-growing counties like Ocean, Monmouth and Burlington also have experienced increases exceeding state and national averages in the growth of their average income levels.

There are slightly more than three million housing units in New Jersey. While there has been substantial new housing construction in recent decades, a large amount of older housing remains, particularly in urban areas. More than a million units, 35.2% of all housing in the State, was built before 1950. Children living in these older units are at high risk of lead poisoning. While the percentage of housing built prior to 1950 ranges from a low of 12% in Ocean County to a high of 60% in Hudson County, every county in the state has at least 10,000 units of pre-1950 housing.

HEALTH and HEALTH CARE INDUSTRY

Overall, adult health trends in New Jersey mirror those in the nation at large. Heart disease, cancer, and stroke, in that order, were the leading causes of death in 1996 in both New Jersey and the nation. New Jersey age-adjusted mortality rates were slightly lower than the national averages for heart disease and stroke, but higher for cancer. In both New Jersey and the nation, age-adjusted death rates in 1996 from these three causes were substantially higher for blacks than for whites. New Jersey mortality rates for blacks due to heart disease and stroke were noticeably lower than the national rates for blacks, while cancer mortality rates were somewhat higher.

New Jersey's health care industry has undergone radical changes in the shift to a market-driven competitive system set up under state legislation in 1992. Throughout the industry, smaller health care facilities, providers, suppliers, and insurers have faced pressure to merge into larger regional and national entities. The resulting deregulated market for health care services has raised concerns over whether competition and the emphasis on cost controls have reduced the quality of treatment, and whether consumer costs will again rise when giant health insurers and hospitals are able to use their market dominance to increase charges for care and insurance. In 1998, New Jersey's fourth largest health maintenance organization was forced to

close due to insolvency and other smaller insurers and providers also were struggling to continue operations. Managed care has undergone tremendous expansion in New Jersey. As of September 1999, 28.7% of the total state population was enrolled in a Health Maintenance Organization (HMO).

Medicaid has completed its statewide initiative to enroll all Temporary Aid to Needy Families (TANF) and TANF related beneficiaries into a managed care system. Only children with special health care needs who are Supplemental Security Income (SSI) recipients or have received a waiver of mandatory enrollment into an HMO are still under a fee-for-service Medicaid system. This subgroup will begin enrollment October 1, 2000. The State's subsidized children's health insurance program, NJ KidCare, has enrolled over 62,000 previously uninsured children, using the same Medicaid network of managed care providers.

INSURANCE

Expanding access to affordable health care continues to be a major goal of public policy. In New Jersey, the percentage of the population under the age of 65 without insurance grew from 11.7% in 1989 to 18.4% in 1997. It is particularly disturbing that this trend has occurred during one of the longest and strongest periods of economic growth in the nation's history. If this trend persists, it has been predicted that 20% of all people under age 65 nationally will have no health insurance by the year 2009. Lack of insurance is particularly prevalent in minority populations, with approximately a fifth of blacks and a third of Hispanics without health coverage. The burden of providing charity care by hospitals, which was eased somewhat by state legislation increasing subsidies in 1998, continues to place financial pressures on hospitals, particularly those serving high numbers of uninsured patients in urban areas.

New Jersey made significant strides in health care reform during the 1990's to improve the access, quality and value of health care services. The initiatives include reforms of the individual and small group health insurance markets, subsidized health coverage through Health Access, Medicaid expansion to 185% of the Federal Poverty Level for pregnant women and infants, Medicaid's move to managed care, and the implementation of NJ KidCare (the Title XXI

children's health insurance program in New Jersey). All of these initiatives have increased access to health care for many of the state's most vulnerable populations. However, Medicaid's implementation of the immigrant provisions of the federal Welfare Reform Act has presented unique challenges to our system of ensuring access to prenatal care to pregnant unqualified aliens. This challenge will be explored further in a subsequent section of this application.

New Jersey's implementation of NJ KidCare, the state child health insurance program, has thus far resulted in the enrollment of over 62,000 uninsured New Jersey children. A full description of NJ KidCare is provided in sections 2.4 and 3.1. Although these numbers are less than originally anticipated, efforts have intensified to improve outreach and enrollment.

A new program to reduce the number of people in New Jersey without health insurance was announced by Governor Whitman during her annual budget address and outlined under a bill sent to the legislature in April. The new health insurance program, to be called FamilyCare, would target "working poor" adults who earn too much to qualify for federal Medicaid assistance, but earn too little to purchase their own insurance or to pay their share of employer-sponsored health insurance. The legislation calls for free or low-cost health insurance for uninsured parents with income up to 200% of the Federal Poverty Level (currently \$34,100 for a family of four). Other uninsured adults with income levels up to 100% of the Federal Poverty Level will qualify. A single adult making up to \$8,350 or a childless couple making up to \$11,250 would be at or below 100% of the Federal Poverty Level. The program would be funded by the State's tobacco settlement money. The State would use the Department of Human Service's existing managed care delivery system.

MATERNAL AND CHILD HEALTH

Maternal and child health priorities continue to be a focus for the New Jersey Department of Health and Senior Services. Specific attention has been placed on the reduction of black infant mortality, reduction of risk taking behaviors among adolescents, and improvements in the quality of care available through Health Maintenance Organizations. This year the Department implemented the recommendations of the Blue Ribbon Panel Report on Black Infant Mortality,

drafted New Jersey Healthy People 2010 and released a third HMO Report Card. These initiatives and reports will be discussed more thoroughly in subsequent sections of this application. The Division of Family Health Services (FHS), the Title V agency in New Jersey, has identified improving access to health services, reducing disparities in health outcomes and increasing cultural competency of services as three priority goals for the maternal and child health (MCH) population. The needs assessment process used by FHS staff to determine the importance and magnitude of maternal and child health needs is described in detail in section 3.2 Needs Assessment of the MCH Population.

The ability and capacity of the State to now provide health insurance to many of the uninsured and underserved children in the state continues to have a profound effect on the way Title V services are being prioritized and implemented. Title V continues to redirect efforts toward enabling services, population-based preventive services, and infrastructure services. This redirection is being tempered by the maintenance of a safety net of services especially for children with special health care needs. Even with reduced financial barriers to health care, challenges persist in promoting access to services, reducing race and ethnic disparities, and improving cultural competency of services.

In addition to health insurance, there are other factors that contribute to the health status of children. Model Community Partnerships for Healthy Adolescents have been formed in ten communities. The State is committed to using a significant portion of tobacco settlement funds for youth tobacco programs. Promoting healthy and safe childcare has also been on the State's agenda. Working with the Department of Human Services, an exciting new collaborative partnership has evolved and resulted in a Healthy Childcare Initiative. This will be described more thoroughly in section 1.5.2 State Agency Collaboration.

Reduction of racial and ethnic disparities in health outcomes is of particular concern to the Department and continues to be a priority in the Division of Family Health Services (FHS) with a focus on infant mortality and adolescent pregnancy. New Jersey is concerned that the rate of black infant mortality is more than double the rate for white infants and the rate of black adolescent pregnancy is more than double that of white teens. In 1996 the Department

established a Blue Ribbon Panel on Black Infant Mortality Reduction which was charged with developing strategies to more effectively use state resources to reduce black infant mortality. The Panel issued its report in September of 1997 and in 1998 the Department convened a Black Infant Mortality Reduction Advisory Council to assist in implementation of strategies to address this most critical issue. The Advisory Council focused its strategies on three areas: education and awareness; cultural competency; and programs and services. A public awareness campaign Black Infants Better Survival (BIBS) is currently underway along with community and professional education which will be further described in Section 2.4.

Preventing adolescent pregnancy is another area where challenges involve statewide collaboration to develop comprehensive services that promote access to needed services, address disparities and target services appropriate for the population including issues of culturally competency. The Advisory Council on Adolescent Pregnancy Prevention established through state statute is bringing together state and community advocates, providers and teens to assist the state in formulating policy and practice to prevent teen pregnancy. Adolescent pregnancy prevention will be further discussed in detail in Section 3.1.

1.5 The State Title V Agency

1.5.1 State Agency Capacity

1.5.1.1 Organizational Structure

The organizational structure of the New Jersey Title V program has changed somewhat since the submission of the FFY 2000 application. Organizational charts are contained in Appendix 1 and show the functional organization of each of the Division's service units. All Maternal and Child Health (MCH) programs including programs for Children with Special Health Care Needs (CSHCN) continue to be organizationally located within the Division of Family Health Services (FHS). All Title V services are under the direction of Celeste Andriot Wood, Assistant Commissioner, Division of FHS.

The Division completed reorganization in July 1998. Several of the service units involved with MCH and CSHCN activities were affected. The resulting reorganization more effectively aligns programs and services targeting the MCH and CSHCN populations and their families. The reorganization combined many of the perinatal and regional services programs with the former Community Health Services unit, which was renamed Maternal, Child and Community Health (MCCH). The Special Child and Adult Health Services Unit was expanded to incorporate Early Intervention Services (the program authorized under Part C of IDEA) and has been renamed Special Child, Adult, and Early Intervention Services (SCAEIS). MCH Epidemiology, previously a program within MCH and Regional Services, is now a part of the Division's Office of the Medical Director, serving all divisional units. There were no changes to the Women Infants and Children Nutritional Program (WIC). Further description of how the reorganization affected specific programs and services follows in the next section.

The mission of the Division of Family Health Services is to improve the health, safety, and well being of families and communities in New Jersey. The Division works to promote and protect the health of mothers, children, adolescents, and at-risk populations, and to reduce disparities in health outcomes by ensuring access to quality comprehensive care. Our ultimate

goals are to enhance the quality of life for each person, family, and community, and to make an investment in the health of future generations.

1.5.1.2 Program Capacity

The mission of Maternal, Child and Community Health Service (MCCH) is to improve the health status of New Jersey families, infants, children and adolescents in a culturally competent manner, with an emphasis on low income and special populations.

Preventive and Primary Care for Pregnant Women, Mothers and Infants

The Perinatal Services Program, within MCCH, coordinates a regionalized system of care of mothers and children through the seven Maternal and Child Health Consortia (MCHC). The MCHC were developed to promote the delivery of the highest quality of care to all pregnant women and newborns; to maximize utilization of highly trained perinatal personnel and intensive care facilities; and to promote a coordinated and cooperative prevention-oriented approach to perinatal services. Continuous quality improvement activities are coordinated on the regional level by the MCHC. The MCHC regional plans now include pediatric need assessments and an inventory of resources including directories of providers.

Many of the Black Infant Mortality Reduction activities are also being administered and coordinated by the Perinatal Services Program including the public awareness campaign and development of community-based programs and services. Several related activities including cultural competency training are a division wide effort and are further discussed in section 3.1.

The Healthy Mothers/Healthy Babies Coalitions target communities with the highest infant mortality and poor pregnancy outcomes and provide community-based planning and grass root outreach programs. In 1997 the merger of eight Healthy Mothers/Healthy Babies Coalitions into four of the MCH Consortia was completed. The Perinatal Health Services Program provides annual funding to the MCHC with HM/HB target cities within their regions. This funding is distributed to local agencies by the MCHC, through a request for proposal process. Guidelines

for funding distribution are established by NJDHSS. Staff within the Perinatal Health Services Program monitor and provide technical assistance to these HM/HB grants. This year the Southern New Jersey Perinatal cooperative in conjunction with the Atlantic City HMHB coalition was awarded a Healthy Start Infrastructure Building Grant. The Healthy Start grant award of Essex County is coordinated through the Perinatal Health Services Program. Fetal Alcohol Syndrome Prevention and Perinatal Addiction Services are also a part of the Perinatal Health Services Program and are further discussed in section 2.4.

Preventive and Primary Care for Children and Adolescents

During the past two years, the Child and Adolescent Health Program, within MCCH, has focused on preventive initiatives in the areas of lead poisoning, immunization, safety, injury, risk reduction, nutrition and physical fitness. Special emphasis has been placed on outreach and education of health care providers and the public to ensure the screening of children under age six years for lead poisoning. Home visiting activities continue through the Prevention Oriented System for Child Health (POrSHE) program and there are new planning efforts to address the problem of asthma in children. The Adolescent Health Program continues to work on reduction of adolescent pregnancy, intentional and unintentional injuries, and improved nutrition and fitness. The MCCH unit continues to be very active in NJ KidCare outreach and enrollment activities.

Preventive and Primary Care for Children with Special Health Care Needs

Special Child, Adult, and Early Intervention Services (SCAEIS) ensures that all persons with special health needs have access to comprehensive, community-based, culturally competent and family centered care. A priority for SCAEIS is ensuring rehabilitative services for blind and disabled individuals less than 16 years old receiving services under Title XIX. SCAEIS receives monthly printouts from the Social Security Disability Determination Unit that identifies all children applying for SSI. Copies of the printouts are sent to the appropriate County Case Management Units. County Case Management Units outreach all SSI applicants and develop

Individual Service Plans that include rehabilitative services and equipment needs for approximately half of the SSI eligible children.

Although not directly supported by Title V funds, a statewide family service network for children and their families affected by HIV are also administered within SCAEIS. This network, consisting of seven sites, has enabled service delivery to over 4,088 infants, children, youth, and families in 1999. In addition, during this past year, enrollment of 236 children, 64 adolescent and adult women, and 1 man into clinical trials has been facilitated through network operations. To publicize the Network and provide education related to HIV disease management for consumers and providers, a web site, www.njfamilyhivaid.org was created in 1999.

SCAEIS works with parent groups, specialty providers and a statewide network of case managers to provide family-centered, community-based, coordinated care for Children with Special Health Care Needs (CSHCN) and facilitate the development of community-based services for such children and their families. In 1999, the Statewide Parent Advocacy Network (SPAN) funded through SCAEIS continued to provide parent support through a three-pronged approach: Project Care, Parent-to-Parent, and Family Voices. Project Care, in existence since 1986, provides statewide family support by fourteen paid parents of children with special needs housed in 11 County Case Management Units. Parent-to-Parent is a telephone support service that matches trained volunteer support parents with other parents of children who have similar health care needs. SCAEIS has enabled Family Voices to develop and organize a New Jersey Chapter of Family Voices. The Family Voices efforts focus on education, advocacy, and expanded outreach to families of children with special health care needs.

1.5.1.3 Other Capacity

Maternal and Child Health Epidemiology Program

Maternal and Child Health Epidemiology Program (MCH Epi) is under the direction of Lakota Kruse, M.D., M.P.H., Medical Director for the Division of Family Health Services. The Office of the Medical Director provides medical and epidemiological consultation for all the

division's programs. The mission of MCH Epi is to promote the health of pregnant women, infants and children through the analysis of trends in maternal and child health data and to facilitate efforts aimed at developing strategies to improve maternal and child health outcomes through the provision of data and completion of applied research projects.

The MCH Epi Program promotes the central collection, integration and analysis of MCH data. Ingrid Morton Mitchell is the program manager for MCH Epi, which is comprised of three professionals, one technician and three support staff. One professional staff member is master's prepared and two professional staff members hold Ph.D. degrees in Demography. All staff members possess extensive experience in statistics, research, evaluation, demography and public health. Additionally, professional staff members have extensive experience with data linking, record matching and epidemiological research. One professional staff position is supported entirely by resources from a CDC Epidemiology Surveillance grant.

Maternal, Child and Community Health

The Maternal, Child and Community Health unit is under the direction of Len Massey, Acting Director, and is comprised of three program managers, 38 professionals, and 24 support staff. All staff members are housed in the central office. Among the professional staff are individuals with nursing, social science, environmental, nutrition, statistical, epidemiology, and other public health backgrounds. MCCH has three major programs: Perinatal Services, Reproductive Health, and Child and Adolescent Health. Administratively reporting out of the Office of the Director is the Primary Care Coordinator and the coordinator for Federally Qualified Health Center (FQHC) Expansion Program Activities.

The Perinatal Health Services program is staffed by nine professionals and seven support personnel and a program manager, Sandra Schwarz. The program is responsible for the regional MCH Consortia, Healthy Mothers/Healthy Babies Coalitions, Certificate of Need rules and MCH Consortia regulations, Healthy Start projects, the HealthStart comprehensive maternity services, the Black Infant Mortality Reduction Initiative, perinatal addictions and fetal alcohol

syndrome prevention projects, and preconceptual health. Resources for staff have been from Federal MCH Block, Preventive Health and Health Services Block, and Healthy Start Grants.

The Reproductive Health Program interacts extensively with the other Title V programs. The Reproductive Health Services program is comprised of a staff of 11 professionals and four support personnel and a program manager, Len Massey. Reproductive Health Services is responsible for the Family Planning Program (Title X) and the Cancer Education and Early Detection Program. Resources for staff programming have been from Federal Title X, Social Services Block Grant, Federal MCH Block, State, and CDC Cooperative Agreement funding sources.

The Child and Adolescent Health Program is comprised of a staff of 15 professionals, 9 support personnel and a program manager, Kevin McNally. Resources for staff have been from state, Federal MCH Block, Preventive Health and Health Services Block Grant and Centers for Disease Control and Prevention Lead Poisoning Prevention grants. All staff members are housed in the central office. Child and Adolescent Health is divided into an early childhood section and a school and adolescent health section. The early childhood section has a coordinator and eight professionals, including two with extensive research and data analysis experience. Most recently a health educator has been added to the child health staff with CDC funds. The State System Development Initiative (SSDI) activities have been incorporated into the child health section to assist with evaluation and performance measure tracking. The school and adolescent health section forms the other half of the Child and Adolescent Health Program. This section is headed by a coordinator with a staff of six professionals, including a research scientist who provides technical assistance and consultation on development of evaluation protocols and is the Division's representative to the department's Healthy People 2010 working group. The Abstinence Education coordinator is also a member of the Child and Adolescent Health staff. Both the early childhood and school and adolescent health staff have varied professional backgrounds including nursing, nutrition, family counseling, health education and environmental health.

Special Child, Adult, and Early Intervention Services (SCAEIS)

Gloria Jones-Grant is the Director of Special Child, Adult, and Early Intervention Services (SCAEIS). SCAEIS consists of the following programs and services: Early Identification and Monitoring, Family Centered Care Services, Child and Adult Special Services, and Early Intervention Services. All SCAEIS staff members are housed in the central office. The Early Identification and Monitoring Program, the Family Centered Care Program, and the Child and Adult Special Services Program are headed by Dr. Marilyn Gorney-Daley, Senior Public Health Physician. Early Intervention Services is headed by Terry Harrison.

The Early Identification and Monitoring Program is comprised of a staff of eleven professionals, eight support staff, and a program manager, Ms. Pam Costa, who holds a Master of Arts and has over 20 years experience in research, design and statistical analysis. Resources for staff come from the MCH Block Grant, the state fee for Newborn Biochemical Screening and the Centers for Disease Control and Prevention Cooperative Agreement. This program is responsible for the reporting and monitoring of children with birth defects and special needs (the Special Child Health Services Registry), newborn biochemical screening follow-up and the Centers for Birth Defects Research and Prevention.

The Family Centered Care Program is comprised of a staff of six professionals, three support staff, and a program manager, Ms. Diane DiDonato, a Registered Nurse, holds a Master's degree in Public Health and has extensive experience in both nursing and public health spanning 30 years. During the past year, a Research Scientist has been hired to conduct outcome evaluation studies related to the HIV Family Centered Care Network and the Statewide Case Management Services delivered through the 21 Title V funded case management agencies.

The Child and Adult Special Services Program is comprised of five professionals, four support staff and a program manager, Ms. Elizabeth Congdon, who holds a Master of Arts degree and is a Registered Nurse with an extensive background in nursing, health education, and public health spanning 30 years. The program has recently hired a public health nurse consultant

with over 20 years experience as a pediatric nurse practitioner with expertise in community health assessment, patient education, and program development.

All programs within SCAEIS have staff with varied professional backgrounds including nursing, medicine, physical therapy, epidemiology, audiology, public health, research, statistics, family counseling, and education. Both senior level and support staff includes parents of children with special health care needs such as developmental delay, seizure disorder, specific genetic syndromes, and asthma.

1.5.2 State Agency Coordination

Family Health Services interacts with many state and local agencies to address MCH issues. Key collaborations are described in reference to specific Title V areas in this section. Fetal Alcohol Syndrome (FAS) prevention is an area where the MCCH and SCAEIS programs are collaborating with the Department of Human Services. Through the Office of Prevention of Mental Retardation and Developmental Disabilities (OPMRDD), a FAS Task Force has been convened to assess and make recommendations regarding FAS prevention. Staff from both units participate on the Task Force, which is currently developing a white paper on the subject. MCCH hopes to use the Task Force report as a basis for modifying prevention programs and services to better reach women at risk. Perinatal Health Services staff collaborate on many other initiatives such as the Child Fatality Review Board and promoting Safe and Stable Families in the Department of Human Services.

Teen pregnancy prevention is at the forefront in New Jersey. The Advisory Council on Adolescent Pregnancy Prevention held its first meeting in April 1999. The Council is in, but not of, the Department of Health and Senior Services. Celeste Andriot Wood, the Assistant Commissioner, Division of Family Health Services, serves as an ex-officio member and MCCH will staff the Council. Ex-Officio representation also includes designees from the Departments of Human Services, Education, Community Affairs, and Labor. Some of the Council's responsibilities include development of policy proposals, promoting a coordinated and

comprehensive approach to the problems of adolescent pregnancy and parenting, and promoting community input and communication.

The WorkFirst Teen Pregnancy Prevention Work Group is another example of successful interdepartmental collaboration. The Department of Human Services serves as lead agency for this initiative and the group has been charged with planning, developing and implementing new initiatives. Using TANF grant funds, \$1.1 million was allocated for Teen Pregnancy Prevention Initiatives. Youth-to-youth programs and mentoring projects are now underway and a Teen Pregnancy Resource Center has been established. MCCH staff participate along with representatives of the Departments of Human Services and Education. MCCH also has the responsibility for the State's Abstinence Only Program.

More emphasis is also being placed on facilitating health and safety in childcare settings. Collaboration between the DHSS and the New Jersey Department of Human Services, Division of Family Development over the past two years has resulted in the establishment of an infrastructure to promote the health and development of young children in childcare settings. A position for a health consultant nurse has been created in the childcare coordinating agencies in every county. Beginning in February 2000, nurses from local health departments and other community agencies are being trained to be health consultants to their local child care providers. Staff from the two Departments collaborated with the State chapter of the American Academy of Pediatrics in an application for Federal Healthy ChildCare America funds. This year the Seventh Annual Health in ChildCare Conference will be held in June.

The dental health component of the Child and Adolescent Health Program is working cooperatively with the New Jersey Dental Society on oral health education activities and the promotion of fluoride mouth rinse programs in schools in communities without fluoridated water. There have also been meetings with the UMDNJ Dental School regarding assistance in preparing educational materials and school-based oral health education in the City of Newark.

School health collaboration and coordination is accomplished through a school health liaison position within the Child and Adolescent Health Program. In December 1999, a joint

retreat was held among the Senior Staff of the Departments of Education and DHSS to develop a Strategic Plan for School Health and a Joint Statement for signature by both Commissioners. The statement affirms both departments' support for comprehensive school health programs. Staff have also collaborated on specific projects, including review of health and physical education standards, development of a protocol for emergency administration of epinephrine, and development and distribution of video and lesson plans on nutrition and physical exercise.

The injury prevention specialist in the Child and Adolescent Health Program participates in the Northeast Injury Prevention Network, a collaborative of the six New England states, New York, and New Jersey. Activities in the past year have focused on suicide prevention, including producing a suicide data book covering the eight states. A regional conference in June 2000 will initiate a process leading to suicide prevention plans for each of the states.

The DHSS participates in the New Jersey Interagency Task Force on the Prevention of Lead Poisoning. Other participating organizations include the State Departments of Human Services, Community Affairs, Environmental Protection, Banking and Insurance, and Labor, as well as statewide professional, academic, and community-based organizations. The task force has developed a Primary Prevention of Lead Poisoning Plan for New Jersey, and has sponsored a number of professional and public education activities, including programs in home supply stores on the safe removal of leaded paint. In 1999, the task force obtained an EPA grant to support lead poisoning education for the staff of Head Start centers and the parents of children enrolled in Head Start.

The Child and Adolescent Health Program manager is a member of the Medicaid Lead Screening Quality Improvement Workgroup. This workgroup was formed by the State Medicaid program in the Department of Human Services to increase the number of Medicaid children screened for lead poisoning. It includes representatives from public health agencies, medical professional organizations, and all the Managed Care companies that have contracts to care for families with children who are enrolled in Medicaid and NJ KidCare. The Workgroup has targeted the city of Trenton for a pilot project, where it is assessing the extent of lead screening

among primary care practices serving Medicaid children and the barriers to lead screening. This information will be used to design interventions to increase the number of children screened.

Coordination between the State's Primary Care Association and Federally Qualified Health Centers continues. The Coordinator of Primary Care works out of the Office of the Director, Community Health Services; the Federal Primary Care Cooperative Agreement is administered by Community Health Services.

In collaborative with the Hospital Association of NJ, Rutgers University, department representatives, and the MCH Consortia, MCCH is developing an evaluation survey to assess the efficiency and efficacy of the MCH Consortia model. Preliminary discussion has centered on the development of a survey to be administered across all consortia to include many diverse constituency groups including hospitals, community groups, clinical professionals, and consumers. Areas to be evaluated include constituent satisfaction, cost effectiveness, performance standards and other related issues.

Special Child, Adult and Early Intervention Services (SCAEIS) and the Statewide Parent Advocacy Network (SPAN) continue to collaborate to improve services to CSHCN. In addition, an initiative between SCAEIS and Shriners Hospital Network formalized the referral relationship between SCAEIS County Case Management Units and the out-of-state Shriners Network System. This formalized system will ensure that the over 4,000 New Jersey children receiving services through the Shriners' Hospitals have access to coordinated community-based health care upon discharge.

FHS has partnered with the Department of Human Services, Office of NJ KidCare to increase the enrollment of children with special needs in the NJ KidCare. Beginning in SFY2001, the Office of NJ KidCare has committed \$500,000 over two years to support this initiative. The department will provide grant funds to the 21 Special Child Health County Case Management Units to support targeted inreach and outreach activities to bolster NJ KidCare enrollment of children receiving case management services.

To assist families of children with special needs in navigating the Medicaid managed care system, a Medicaid Managed Care Alliance was formed in October 1999. This alliance is comprised of parents, advocacy groups, representatives from the DHS Office of Managed Care, NJ KidCare, HMO case managers, SCAEIS case managers and others. A statewide conference for health care providers/consumers will be conducted in late summer 2000 to open avenues of communication between families with special needs children, health care providers and the HMOs.

In January 1999, the national prevention campaign on reducing neural tube defects (NTD) through folic acid was launched in Washington, DC. As a result, staff from the Division of Family Health Services, including representatives from WIC, Family Planning, Child and Adolescent Health and SCAEIS, are now collaborating with numerous organizations in New Jersey to increase awareness and use of folic acid. The Folic Acid Coalition of New Jersey has been formed, and includes such agencies and organizations as the March of Dimes, the Spina Bifida Association, the DHSS, the Department of Human Services, the MCH Consortia, and Newark Beth Israel Medical Center. Over the past year, the groups have formed a number of subcommittees to better address the two primary goals of the coalition: the reduction of the number of NTD-affected pregnancies and to increase the number of women taking folic acid. These subgroups include education, media, and public awareness. Some of the recent activities of the coalition have been to form a speakers bureau, advocate/ensure that the folic acid message is included in a broader array of consumer/professional meetings, and investigate formation of training modules for a variety of professionals.

In March 2000, Governor Christine Todd Whitman announced her "Children's System of Care" initiative which will be a new system of comprehensive services for children with mental illness or severe emotional and behavioral problems. The Governor has proposed \$39 million in new funding next year to create this centralized system. SCAEIS staff both welcome and anticipate collaborative efforts regarding this initiative. Currently, SCAEIS staff is represented on the Community Mental Health Board and Planning Council.

Staff from the Early Identification and Monitoring Program are part of the department's newly formed working group to improve physician reporting. The department has recognized the need to address physician compliance to required state and federal public health initiatives, including birth defects. The group's purpose is to investigate barriers and issue recommendations for improving compliance. The group is comprised of various department divisions (AIDS, FHS, Epidemiology, Local Health, and Health Planning), the office of the state epidemiologist, and numerous professional organizations and medical/health agencies, such as the Board of Medical Examiners, the Infectious Diseases Society of New Jersey, the New Jersey Public Health Association, the New Jersey Health Officers Association, and the Medical Society of New Jersey.

Through the activities of the Centers for Birth Defects Research and Prevention, staff from Special Child, Adult and Early Intervention are building collaborative relationships with numerous agencies in New Jersey, such as the University of Medicine and Dentistry in New Jersey (Newark and New Brunswick facilities), the Children's Hospital of New Jersey at Newark Beth Israel Medical Center, the Environmental and Occupational Health Sciences Institute, Rutgers University, and the Division of AIDS. Additionally, Centers' staff has also developed a strong network with the other seven national Centers and other researchers. The focus of the collaborations has been to improve the surveillance of birth defects and to initiate a variety of research projects to further the understanding of the causes of birth defects. Among the funded projects is the formation of a fetal abnormality registry, which will document the occurrence of birth defects among pregnancies as opposed to live births. This data is critical for calculating accurate rates of the occurrence of birth defects, including better information on the evaluation of the impact of folic acid on pregnancies affected by neural tube defects. Another example of a local research project will be the investigation of the role of endocrine disruptors on the occurrence of hypospadias. Staff within Special Child, Adult and Early Intervention Services will also collaborate with the Division of AIDS on a project that will link the AIDS/HIV Registry with the Special Child Health Services Registry to investigate the role of maternal anti-retroviral drug use during pregnancy on birth outcome. New Jersey will also participate, via sub-grants, on multi-state investigations of both cleft lip and palate and Down syndrome.

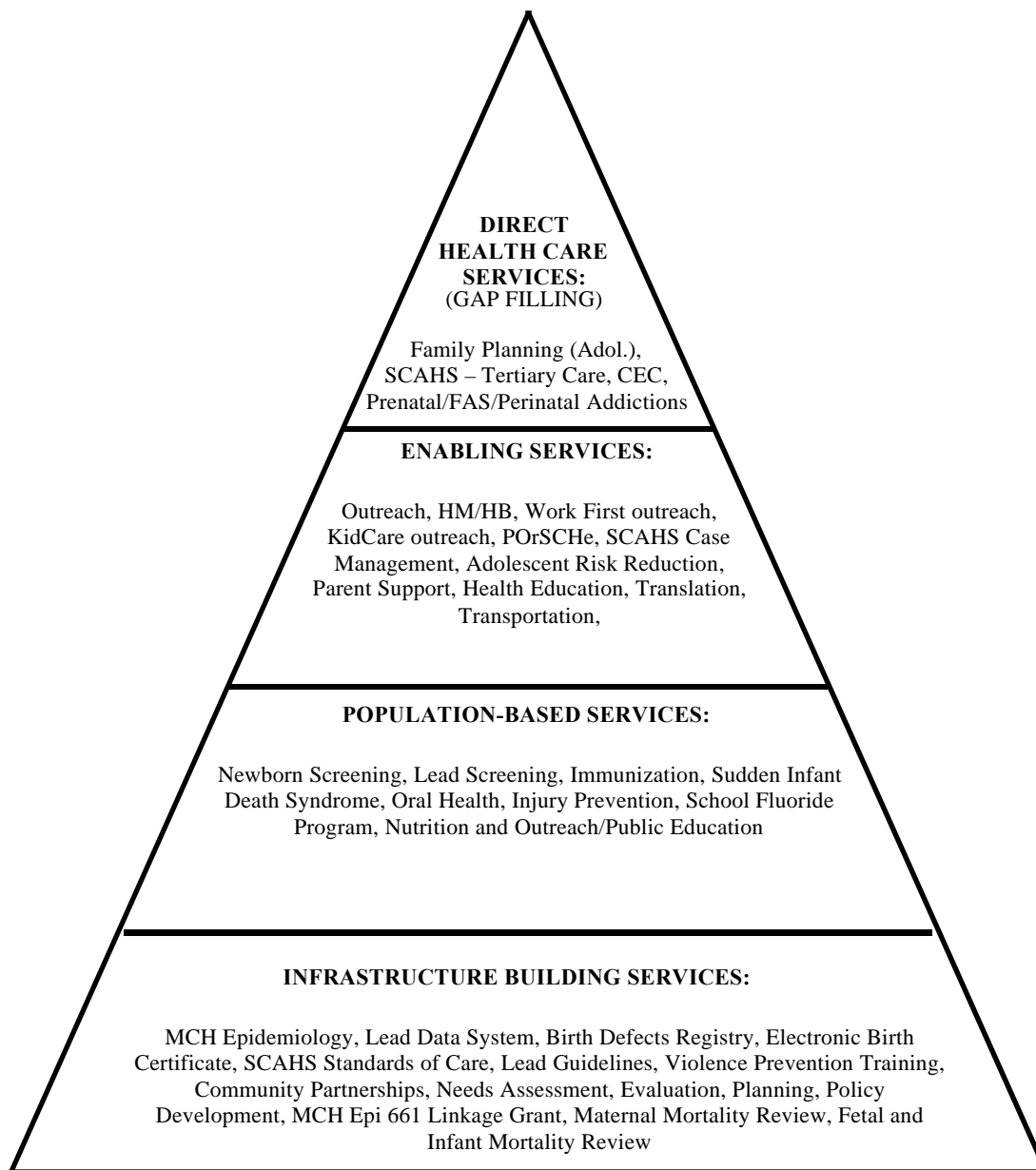
II. REQUIREMENTS FOR THE ANNUAL REPORT [Section 506]

2.1 Annual Expenditures

Annual expenditures are summarized in Form 3, 4, and 5. Form 5, State Title V Programs Budget and Expenditures by Types of Service, parallels the pyramid shown in Figure 1 which organizes Maternal Child Health Services hierarchically from direct health care services through infrastructure building. There are no significant variations between fiscal year budgeted and expended funds or between fiscal year expended funds columns.

Figure 1

CORE PUBLIC HEALTH SERVICES DELIVERED BY NEW JERSEY MCH AGENCIES



2.2 Annual Number of Individuals Served

The annual number of individuals served under Title V is summarized in Forms 6, 7, 8, and 9.

2.3 State Summary Profile

The Title V Maternal and Child Health Block Grant Service Profile is summarized in Form 10.

2.4 Progress on Annual Performance Measures & Outcome Measures (Table 2)

Many of the accomplishments of the Title V program may be applicable to more than one performance measure and therefore will be described only in the area of greatest relevance. Table 1 summarizes Core Performance Measures (CPM), State "Negotiated" Performance (SPM) Measures, and Outcome Measures (OM). Progress on CPM, SPM, OM and new Health Status Indicators (HIS) is provided in Forms 11, 12, C1, C2, C3, D1 and D2.

Direct Health Care Services

MCCH through the Perinatal Health Services Program continues to support Fetal Alcohol Syndrome (FAS) prevention projects and perinatal addiction treatment services in 11 locations. The FAS/Perinatal Addictions staff person participates on the state's FAS Prevention Task Force, which is currently developing a state prevention plan as described in section 1.5.2 State Agency Coordination. In addition, 106 prenatal providers have continued to provide comprehensive health services and maternity and newborn services in order to address very low birth weight live births (Performance Measures #16), very low birth weight infants delivered at facilities for high-risk deliveries (Performance Measures #18), and first trimester prenatal care (Performance Measures #16). The prenatal care providers include 70 hospitals that provide maternity services; six HMOs contracted through the Department of Human Services, 12 private physician practices, 11 FQHCs, four Planned Parenthood agencies, and three licensed

ambulatory care agencies. All of the facilities are certified by Medicaid to provide HealthStart maternity services, and 90 are certified to provide presumptive eligibility screening.

New Jersey has achieved an 85% age appropriate immunization rate (1998), based on CDC and state retrospective studies. To address age appropriate immunizations (Core Performance Measure #5), the Immunization Program in the Division of Communicable Diseases continues to support immunization at clinics in local health departments, Federally Qualified Health Centers, and other pediatric clinics. Currently being expanded statewide is the New Jersey Immunization Information System (NJIIS). NJIIS is designed to be an electronic repository for information on the immunization status of New Jersey children. There are presently over 170,000 children in the database and the system has been installed at 99 sites. The State's Vaccines for Children Program became available to private practitioners for the first time in 1999. FHS continues to work collaboratively with the Immunization Program to promote age appropriate immunizations.

Seventeen family planning agencies with 58 clinical sites provide comprehensive reproductive health services to over 25,000 adolescents each year to assist the Title V program to meet Core Performance Measure # 6, reduction of births to teens 15 - 17 years of age. Clinical services are provided including physical assessment, laboratory testing, and individual education and counseling for all FDA approved contraceptive methods.

Family planning agencies also provided community education and outreach to the adolescent population. Aimed at schools and community groups, education activities deal with decision-making, value clarification and establishing linkages with youth-serving agencies. Educational activities focus on primary pregnancy prevention activities that encourage family communication, promoting self esteem, postponing sexual activity and promoting effective contraception. All family planning agencies have implemented an enhanced service package, which for Medicaid beneficiaries is a reimbursable service. The program integrates assessment of adolescent risk behavior within routine family planning services. Through direct individual preventive education or through referral, the program promotes behaviors of healthy lifestyle,

injury prevention, drug, alcohol and tobacco prevention, as well as, sexually transmitted disease (STD) and pregnancy prevention.

During 1999 SCAEIS continued to ensure that Supplemental Security Income (SSI) beneficiaries less than 16 years old received rehabilitation services (Core Performance Measure #1). Although SCAEIS does not provide direct rehabilitative services to SSI beneficiaries, the program does provide the outreach and case management services to ensure that SSI beneficiaries receive these necessary services. In New Jersey, SSI beneficiaries who meet family income guidelines are eligible for comprehensive Medicaid benefits, which include the rehabilitative services of audiology, physical, occupational, and speech therapy. All New Jersey children applying for SSI disability are referred by the State SCAEIS office to the County Case Management Units through a letter of agreement with New Jersey Department of Labor, Disability Determinations. SCAEIS has currently revised reporting forms to track the exact number of SSI beneficiaries less than 16 years old who receive rehabilitative services. Exact numbers are expected for SFY 2000. In 2000, an estimated 2,500 SSI beneficiaries less than 16 years old will have an Individual Service Plan which includes rehabilitative services developed for them by the County Case Management Units.

Despite challenges created by a rapidly changing health care environment, SCAEIS has continued to ensure the availability of specialty and subspecialty services, including care coordination, not otherwise accessible to children with special health care needs (CSHCN) (Performance Measure #2). The CSHCN programs in New Jersey have traditionally provided and/or financed specialty and subspecialty care services through a network of specialty clinics. More emphasis continues to be placed on providing care coordination through the County Case Management Units. With many families transitioning to managed care, the care coordination services of County Case Management Units are now even more important to ensure comprehensive care due to potential restrictions created by utilization review, referral requirements, and closed panel networks. Anecdotal experience this past year has proven the benefits of the County Case Management Units who have assisted families in navigating the complicated managed care system to obtain necessary services.

To assist families in accessing the Medicaid managed care system, SCAEIS County Case Managers continue to provide consultation, advocacy, information and referral to access comprehensive health care coverage. In an effort to assist families of children with special needs in navigating the Medicaid Managed care system, a Medicaid Managed Care Alliance was formed in October 1999. This Alliance, funded through a special \$10,000 grant from the MCH Bureau, is comprised of parents, advocacy groups, representatives from the DHS Office of Managed Care, NJ KidCare, HMO case managers, SCAEIS case managers and others. A brochure entitled "Finding Your Way through Medicaid Managed Care... For Families with Children with Special Needs" will be distributed statewide once completed. In addition, a statewide conference for health care providers/consumers will be conducted in late summer 2000 to facilitate use of the brochure and open avenues of communication between families with special needs children, health care providers and the HMOs. In the Pediatric HIV Family Centered Care Network, each of the Network agencies has entered into linkage agreements with the managed care systems operating within their catchment areas. These agreements will ensure the delivery of coordinated primary and specialty care for the HIV affected special needs children and their families.

SCAEIS continues to provide or subsidize direct specialty and subspecialty services to CSHCN by funding Child and Adult Special Services which includes: eight Child Evaluation Centers, two PKU Treatment Centers, five Cleft Palate Centers, three Tertiary Centers, nine Genetic Centers, three Hemophilia Centers and six Sickle Cell Centers. Services are provided to the uninsured and underinsured utilizing a sliding-fee-scale and include a comprehensive array of services consistent with the multidisciplinary team approach to advocate for CSHCN. Approximately 70,000 children received services within the specialty network during 1999. Additionally, a special insurance program is available for those individuals with Hemophilia A or B who do not have access to any of the traditional insurance programs. Several special projects have recently received funding with the goal of improving health care outcomes for those individuals with Sickle Cell diseases and other hemoglobinopathies. These projects include a newsletter and Internet site, Pen-Pal program, support groups, and the development of a transitional program for teenagers and young adults to ensure continued access to quality hematology services.

Enabling Services

Through the Healthy Mothers/Healthy Babies (HM/HB) Coalition program, the enabling services of outreach, supportive services, and education are provided to improve maternal and infant care (Core Performance Measures #5, #17, #18, and Health Status Indicators #2, #3, #4, #5). For example, the Southern New Jersey Perinatal Cooperative in conjunction with the Atlantic City HM/HB Coalition is providing outreach workers accompanied by bilingual interpreters to perform door-to-door canvassing and educational activities. This program locates women who have missed prenatal appointments and assists new mothers in obtaining pediatric care for their children. Age appropriate immunizations and comprehensive pediatric and prenatal care are the focus of the outreach activities. The target is approximately 200 referrals to services annually. The Camden HM/HB Coalition uses the Community Connection Project to identify women between the ages of 20 and 35 who are in need of more intensive contact based on initial evaluation. Interventions with these women are documented with appropriate follow up. Through canvassing and emergency referrals pregnant women not in care are identified. Outreach workers will assist in making appointments and appropriate referrals for these women and will provide follow up care. Barriers to care will be identified and reported to their Community Network Committee.

In the Northern New Jersey Maternal and Child Health Consortium, the Paterson Coalition provides a Perinatal Outreach Program utilizing two full time Outreach Workers. These Outreach Workers target low-income pregnant women living in the City of Paterson. Women are identified through door-to-door canvassing. The goal is to locate and educate 400 women about health care services with an emphasis on prenatal care. The focus will shift to provision of phone, home, and community follow up, referral, health education and development of a tracking system for high-risk pregnant women. The Paterson HMHB program also promotes preventive health care, while increasing age appropriate immunizations of infants and preschool age children in Paterson by working in conjunction with the City of Paterson Health Department's Safety Net Program. Children are followed through age two years to monitor age appropriate immunization status.

The Prevention Oriented Services for Child Health projects (POrSCHe) continue in 11 of New Jersey's 21 counties. Six of the target areas are cities and five of the projects are county-based. The initiative began in January 1997. Approximately 1,500 families are being served annually by POrSCHe projects. The POrSCHe projects were designed as outreach case management models to assist primary health care providers. Through POrSCHe, families are provided services that include: identification of health, nutritional, or developmental problems; supportive anticipatory guidance in child growth and development and parenting skills training and counseling; specialized health education to promote age appropriate immunizations, healthy eating and safety habits including, but not limited, to car seat restraints; and regular health supervision visits to a primary care provider. Additionally, the home visitor provides assistance to parents in accessing community resources (WIC, family planning, housing, education, job training and other social services). Evaluation of the projects is based on performance and outcome measures including: linkage with a primary care provider; enrollment in WIC, Medicaid (CPM #13), age appropriate immunizations (CPM #5) and lead screening; follow up to ensure decreasing blood lead levels for affected children; referral for all appropriate services; and increase in parenting skills as measured by Nursing Child Assessment Satellite Training (NCAST).

Although not specifically focused on deaths due to motor vehicle crashes, progress has been made on unintentional injury prevention activities (Core Performance Measure # 8). POrSCHe projects instruct families in child safety including use of infant car seats and child restraint systems. Safety at home and in the childcare center is one of the major focuses of the Healthy ChildCare Initiative.

Adolescent parenting projects, two in Newark and one in Bridgeton serving Cumberland County, continue to use home visiting to promote the physical and psychosocial health of low income childbearing adolescents and their infants. To meet State Performance Measure # 5, the programs serving over 250 pregnant or parenting teens, are supporting their goals to complete high school or GED requirements, linking them to primary care providers, ensuring that both the teen and infant receive preventive and primary health care, and preventing unintended

pregnancies. Since the inception of the programs, the rate of repeat pregnancies among participants has been 5%, there have been no substantiated child abuse or neglect cases, and over 95% of the children are age appropriately immunized.

MCH resources also continue to support a Young Fathers Program in Newark. The Program provides counseling services to young men between the ages of 15-23 years to enhance their social and emotional functioning, increase their financial independence, and promote responsible behavior.

In addressing Core Performance Measure # 6 Teen (15-17) Birth Rate, collaboration with the Department of Human Services relative to teen pregnancy prevention activities this year has focused on development of community-based activities for Teen Pregnancy Prevention Month (May). A statewide planning summit was held in March 1999 and brought together community organizations, advocates and teens to plan for local activities. Additionally, intradepartmental planning has commenced to expand the scope of the World AIDS Day of Learning for Youth to include peer leadership training on teen pregnancy and STD prevention.

State Performance Measure #10 focuses on increasing community partnerships for healthy adolescents and was developed as a result of the needs assessment and deliberations of the Adolescent Health Team. It is intended to track efforts to develop programs which would create an infrastructure of community partnerships that are dedicated to helping adolescents and their families overcome challenges through consistent and coordinated approaches. Currently, partnerships are being funded in ten communities with MCH Block Grant funds. Each grant supports a full-time coordinator to staff a community-wide coalition of agencies serving adolescents. The intent is to promote a comprehensive approach to adolescent health, rather than the usual categorical response to particular problems.

A full day conference with 280 participants was held in conjunction with the Mercer County Traumatic Loss program (a grantee of MCCH) and addressed the topics of teen suicide, self destructive behavior, contagion concerns, parent education, and sexual identity issues. This activity was conducted to address the rate of suicide deaths among youth age 15-19 (Core

Performance Measure #16). As described in our last application, “Managing Sudden Traumatic Loss in the Schools” (revised edition) is made available to schools and other youth serving organizations upon request. The document outlines a model for responding to the needs of the general school population after a suicide, homicide or sudden accidental death.

To reduce the number of uninsured children in New Jersey (Core Performance Measure #12), the Department of Health and Senior Services continues our collaborative relationship with the Department of Human Services, the lead agency for the NJ KidCare Initiative. Title V staff represent the DHSS on the Outreach and Enrollment Subcommittee. Title V has included language within our specifications for health service grants to require agencies providing health enabling services to outreach and facilitate enrollment of potentially eligible children. To facilitate this process, a Memorandum of Understanding between DHS/NJ KidCare and DHSS/Division of Family Health Services was developed to provide funding to ensure outreach and enrollment of CSHCN and their families. The Outreach and Enrollment Plan also calls for the utilization of the electronic birth certificate (EBC) to identify families of newborns without health insurance, as well as the WIC and Immunization Registries/Databases. Information from the EBC is now shared with NJ KidCare for purposes of outreach.

Special Child, and Adult Services and Early Intervention Services (SCAEIS) provides enabling services to children with special health care needs (CSHCN) in order to ensure a “medical/health home” (Performance Measure #3). SCAEIS has promoted the concept of a “medical home” as defined by the American Academy of Pediatrics through case management services, collaboration with the Statewide Parent Advocacy Network (SPAN), and support of the Child and Adult Special Services Program providers. SCAEIS participated in the “Your Voice Counts” study beginning in August 1998, a collaborative effort between Family Voices, Brandeis University, and Title V agencies. Two hundred families involved in case management were surveyed to learn about their experiences with health insurance, managed health care, and the health system. The survey included questions regarding status of primary care provider, coordination of care, access to specialists and therapists, and other health issues. Preliminary results indicated that 89% of respondents reported that their child had a primary care provider. The majority reported having a case manager, either through their primary health insurance plan,

MCH program, state Developmental Disabilities program, or other affiliation, and that the case manager was of assistance in coordinating care. Additional New Jersey specific results are anticipated to be available in Spring 2002 and should be helpful in highlighting areas of improvement in access to care. New Jersey is looking forward to the national survey initiative developed by the Maternal Child Health Bureau and the National Center for Health Statistics for a State and Local Area Integrated Telephone Survey (SLAITS) of CSHCN.

Approximately 10,500 children are newly referred to the Special Child Health Services (SCHS) County Case Management Units each year, and all are offered case management/care coordination including development of Individual Service Plans (ISP) that address assessment of and need for comprehensive health, education, social, and rehabilitative services. Included in the ISPs are enabling services such as transportation, economic assistance, service linkages, respite care, and general support in terms of rights and safeguards. Case managers work with these families and their physicians to ensure care that is accessible, continuous, comprehensive, family-centered, coordinated, and compassionate.

Collaboration between the Statewide Parent Advocacy Network (SPAN) and SCAEIS, which began eight years ago, has enhanced the provision of accessible family-centered care. SPAN is the only federally funded parent training and information center for parents of children with disabilities and special health care needs in New Jersey. During 1999, eleven Case Management Units housed 14 SPAN Resource Parents who provided technical assistance and support to families and/or staff in the areas of specific disabilities and education, as well as transition to preschool and adulthood issues. The Resource Parents documented nearly 6,000 contacts with families and professionals during that time. In addition, SCAEIS provided full funding in 1999 for a project enabling volunteer parents trained through SPAN to provide statewide coverage for the New Jersey Parent to Parent Program. As another statewide initiative, SCAEIS participated in the development of a Family Voices chapter, whose mission is to provide parents with training in family leadership, policy making, and advocacy in health care.

SCAEIS promotes accessibility to well-trained physicians and other providers experienced in the comprehensive management of CSHCN through funding of Child and Adult

Special Services which includes: eight Child Evaluation Centers, two PKU Treatment Centers, five Cleft Palate Centers, three Tertiary Centers, nine Genetic Centers, three Hemophilia Centers and six Sickle Cell Treatment Sites. This network of centers served approximately 70,000 children in 1999.

Population-Based Services

One essential population-based service in New Jersey is newborn screening for inborn errors of metabolism (Core Performance Measure #4). Supported through fees raised from the sale of the newborn screening kit, this program strives to ensure that all newborns in New Jersey are tested for four metabolic disorders that can be treated effectively if detected early. Within SCAEIS, the Newborn Biochemical Screening follow up staff are responsible for the follow up of all infants who have not normal screenings. The goal is to arrange for confirmation, initiation of diagnosis, and treatment (SPMN #2) within nationally established time lines: PKU - three weeks; Congenital Hypothyroidism - three weeks; Galactosemia - one to two weeks; and Sickle Cell - two months.

The MCH Epidemiology program is completing year 4 of a five year CDC research grant to further improve newborn screening rates (Core Performance Measure #4) and to identify infants at risk for death and developmental delays. This year's efforts included the completion of linkages between the Electronic Birth Certificate (EBC) and the Newborn Biochemical Screening data for 1998. Matched records confirmed the screening rate of greater than 99.7% of all newborns. Efforts to confirm individual unscreened newborns, to explain systematic problems and to improve future screening are ongoing. Efforts aimed at increasing screening rates are focusing on software integration at the hospital level between the Newborn Biochemical Screening and EBC software programs.

Statewide implementation of the Electronic Birth Certificate in 1997 now permits the detailed tracking of the percentage of mothers who breastfeed their infants at hospital discharge (State Performance Measure #9). Data from 1999 demonstrate an increase in breastfeeding to 60.2% of newborns discharged to home; 43.7% of discharged newborns were exclusively

breastfed at the time of hospital discharge. Direct services to promote breastfeeding continue to be funded by the Special Supplemental Food Program for Women, Infants and Children (WIC) as grants to the Maternal Child Health Consortia. Prenatal and postnatal breastfeeding support services are provided at WIC sites, prenatal care sites and in hospitals to WIC participants. Broader population-based provider education is being provided as in-services and Grand Rounds presentations at selected clinics and hospitals.

The role of preconceptual health and its impact on preterm birth, low birth weight (LBW) and very low birth weight (VLBW) has gained more attention. Preconceptional health counseling training was presented regionally for health care providers during the past year as Train-The-Trainer symposia sponsored by three Maternal and Child Health Consortia (MCHC). About 100 health professionals participated in the symposia that were taught by Merry K. Moos, Research Associate Professor, University of North Carolina, School of Medicine. The evaluation of training sessions indicated high ratings, as well as meeting learning objectives. A six months Preconceptional Information Survey of participants conducted in 1999 indicated that 59 percent of the trainees had integrated preconceptional health with their on-going MCH programs, and 42.5 percent had either sponsored a training or were planning the joint sponsorship of a preconceptional health project. A similar local follow-up survey that was conducted by one of the three MCHC in 1999 confirmed the Preconceptional Information Survey findings.

To build upon the above activities, Year 2000 has been designated as Preconceptional Health Promotion Year in New Jersey. The Healthy Mothers/Healthy Babies (HM/HB) Coalitions have been alerted to play a key role in preconceptional health education and promotional activities. To this end, a total of 10,000 selected educational pamphlets, i.e., 5,000 related to preconceptional health and 5,000 related to the importance of taking 400 micrograms of folic acid daily by prospective pregnant women and adults of childbearing age will be disseminated throughout the State. A Folic Acid Initiative is also being sponsored by the Perinatal Health Services Program in cooperation with the March of Dimes Birth Defects Foundation, which is coordinating the Folic Acid Coalition of New Jersey.

During the reporting period there has been significant activity to address Outcome Measure # 2, reducing Black infant mortality, and State Performance Measure #1, reduction of the percent of Black preterm births. The Black Infant Mortality Reduction Advisory Council has assisted the Department in several new and exciting initiatives. The public awareness campaign Black Infants Better Survival (BIBS) is the culmination of a concerted effort on the part of the Department in response to recommendations of the Blue Ribbon Panel Report and the Advisory Councils priority interests. The campaign was unveiled in May 1999 and will run for two years. The State awarded a contract to Nancy Becker and Associates, along with Wise Choices and Princeton Partners, to increase public awareness about the disparity between Black and white infant mortality within the black community. The public awareness and community education components of the campaign are targeted to get information out to Black women of childbearing age and their families concerning the increased risk and strategies to improve pregnancy outcomes. A third component, professional education, targets health care providers to increase awareness, provide current data, dispel myths, suggest strategies for intervention, and discuss the impact of cultural competency on Black infant mortality. As part of the campaign a separate toll free line (1-888-414-BIBS) was linked with the MCH toll free Family Health Line and was established to answer questions from the public about Black infant mortality and to make referrals. The link to the Family Health Line ensures easy access to local resources for callers. Together Inc. is the contractor for both lines and coordinates responses. The Northern New Jersey MCH Consortium has served as the Black Infant Mortality Reduction Resource Center since July 1999 offering technical assistance, professional consultation and acting as a clearinghouse for materials and research on BIMR.

The Division of Family Health Services also developed and implemented a cultural competence training initiative. The division's goal is to develop a seamless delivery system of culturally competent health care to the increasingly diverse citizens of New Jersey. The division formed a Family Health Services Diversity Team, which was responsible for coordination and planning for the initiative. The need for cultural competency training is discussed in Section 3.2.1 of this application. The first step in the division's plan was to offer and provide health service grantees with training that specifically addresses cultural sensitivity and competency within a health care delivery system. Those organizations and agencies that were supported with

grant funds have had the opportunity to send staff to a train-the-trainer program so that they may share what is learned with their colleagues. Over 300 staff were trained in two separate two-day workshops in February 1999.

The SIDS Center of New Jersey (SCNJ) continues to provide comprehensive clinical and counseling services to families and serves as the primary resource for educating the public and professionals about SIDS. All New Jersey SIDS related data and research endeavors are coordinated by the SCNJ. SIDS Family Services is the parent-to-parent support network in New Jersey. Preventive education regarding SIDS has contributed to the significant decrease in SIDS death rates. Since the onset of the national risk reduction campaigns and that of the SCNJ, the rates has dropped from .9/1000 in 1993 to .5/1000 in 1997 or 108 and 57 deaths attributable to SIDS respectively. Major efforts are now focused on reducing the disparity that still exists between SIDS deaths in the black and white populations. A targeted campaign has been underway in the State's urban centers.

During the reporting period significant progress was made toward State Performance Measure # 4 regarding childhood lead poisoning prevention. Extensive training was provided during this past year to the staff of local health departments regarding their responsibilities for investigation of cases of lead poisoning under the newly revised state regulations adopted in June 1999. Beginning July 1, 1999, all blood lead test results are being reported by laboratories to the Department. Between July and December, more than 70,000 blood lead tests were reported. This is being accomplished either through electronic transmission via the Internet, submission of diskette or hardcopy reporting. For the first time determinations of the incidence and prevalence of childhood lead poisoning in the state will be possible. The opportunity to assess the location and extent of the problem will be provided so that programs can be targeted to the most at risk areas. Working with the state's Immunization Program, the childhood lead poisoning prevention section of Child Health is developing a lead screening module for the Immunization Registry. Information from the lead data system will be downloaded into the Immunization Registry for easy retrieval by practitioners and the data from the Immunization Registry will be used to update the lead data base as appropriate. The WIC Program has included within its database a module on immunizations, which also interfaces with the Immunization Registry. Additionally,

Child Health staff have participated in a collaborative effort with Medicaid and its contracted Managed Care providers to increase the number of Medicaid-enrolled children screened for lead poisoning.

The childhood lead poisoning prevention program continued to support the cost of laboratory testing of blood lead levels for children without any other source of payment through the DHSS Blood Lead Laboratory. The number of blood lead tests has continued to decline due to the shift in responsibility for lead screening to the primary care provider and subsequent increased use of private laboratories. In 1999, the state's Blood Lead Laboratory completed less than 10,000 tests, which is down from 27,000 in 1995.

All children with elevated blood lead levels that require public health intervention are eligible for POrSCHe services (described earlier in this section) in target areas. Children in other areas of the state with elevated blood lead levels are served by their local health department as required by the State Sanitary Code (Chapter XIII).

In our highest risk city, Newark, the Child and Adolescent Health Program has partnered with the Newark City Department of Health and Human Services to establish the Newark Partnership for Lead Safe Children. The partnership has enlisted the support and participation of over 30 agencies/organizations in Newark. The partnership has been designed to empower the city and participating organizations to "take charge" of the lead problem in Newark. A primary prevention plan for the city is under development, and preparation of the first two parts of this plan, a need assessment and a resource inventory of all organizations in Newark currently performing activities related to lead poisoning, has been completed.

In the area of oral/dental health, support continues for a dental consultant and three dental hygienists who act as regional dental coordinators providing oral health education to preschool and elementary school students through the Cavity Free Kids program and Save Our Smiles, a school fluoride mouth rinse program, serving over 125,000 children. A Directory of Fluoridated Water Systems was published and disseminated to dentists in cooperation with the New Jersey Dental Society. The Directory is also available on the Department's web site. Staff is currently

developing a survey of third grade children who have received protective sealants on at least one permanent molar tooth to determine the State's progress on meeting Core Performance Measure # 7. The FQHC Expansion program continues to provide financial support of dental health services. The total capacity of the FQHCs dental services is 56 dental operators in 11 of the 12 FQHCs in New Jersey. Additionally, the Physician/Dentist Loan Redemption Program has placed 11 more dentists in underserved areas of the State.

State Performance Measure # 10, the development and implementation of a state plan to improve nutritional status and physical fitness of children and adolescents, has been partially achieved. By accessing technical assistance support through the MCHB Region II, a consultant was brought to New Jersey and convened a meeting with all interested parties. The result was an outline of a plan for the state to refine. The plan is currently being refined and will include efforts to promote the use of folic acid and calcium, as well as healthy eating habits and physical fitness, throughout many of our programs.

The Osteoporosis Awareness and Education Act became law in 1997 and included a state appropriation. Primary prevention of osteoporosis must begin in childhood and continue through adolescence in order to build healthy bone mass. Activities during this grant year have focused on community-based initiatives to promote healthy eating behaviors and physical activity through the Community Partnerships for Healthy Adolescents initiative. Osteoporosis activities are coordinated with the Division of Senior Affairs, with consultation with the Interagency Council on Osteoporosis.

The statewide implementation of an Electronic Birth Certificate (EBC) in 1997 now permits the Newborn Hearing Screening Program to monitor the percent of newborns screened for hearing impairment before hospital discharge (Core Performance Measure #10). Preliminary data for 1999 indicates that 41% of newborns are screened prior to discharge. Using the EBC, the Newborn Hearing Screening Program can also identify and track children at "high-risk" for hearing loss and those who failed initial electrophysiological screening tests. Currently all parents of "high-risk" newborns not screened for hearing impairment before hospital discharge are sent a letter recommending screening by three months of age. Effective May 15, 2000,

readoption of the newborn hearing screening rule with amendments will be published in the New Jersey Register. The amended regulations include: 1) a requirement for all birthing facilities to provide electrophysiological hearing screening prior to discharge or before one month of age for all babies having indicators associated with hearing loss, and 2) a requirement for all birthing facilities to screen all newborns electrophysiologically, regardless of the presence or absence of risk factors, prior to discharge or before one month of age by the year 2002.

Early identification and AZT treatment of pregnant women identified as HIV infected appears to be reducing perinatal transmission to newborns. In looking at the number of reported cases of HIV/AIDS born in New Jersey, the number of infected cases dropped from 70 in 1993 to 6 in 1999 (State Performance Measure #9). The incidence of HIV positive infants born in New Jersey continued to decline in 1999. Each of New Jersey's seven Pediatric HIV Family Care Centers has a dedicated perinatal care coordinator who is responsible for targeting outreach, counseling, testing and long-term follow-up of high risk adolescents and women of child bearing age. Pregnant women identified as HIV positive are referred to specialty clinics within the network. AZT treatment is provided during pregnancy, delivery and to newborns according to the CDC protocol. All newborns are referred and managed within the network. Co-located mother-child or family clinics have been established in each site to facilitate long term maintenance of mother and child in care. Preliminary data from the linking of mother/infant pairs indicates that 55.3% of perinatally exposed children born in New Jersey in 1998 had a history of receiving AZT prenatally, perinatally, and/or neonatally. With improvements in data collection and increased outreach and referral, the percentage of perinatally HIV exposed newborns appropriately treated with antiretroviral therapy should increase.

Infrastructure Building Services

New Jersey has prided itself on its MCH programs, which have been provided through the Maternal Child Health Consortia (MCHC), an established regionalized network of maternal and child health providers with emphasis on prevention and community-based activities. The consortia are charged with developing regional perinatal and pediatric plans, total quality improvement systems, professional and consumer education, transport systems, data analysis,

and infant follow-up programs. Specific programs include the activities of eight Healthy Mothers/Healthy Babies Coalitions, Fetal Alcohol Syndrome and Perinatal Addictions projects, Healthy Start of Essex County, preconceptional health counseling, and facilitation of the Black Infant Mortality Reduction initiative. These activities have continued to expand during the reporting period and have gained the attention of other department programs. The Gateway MCHC is the recipient of a grant from the Immunization Program for the Partners to Immunize Newark Kids Coalition. The grant supports a variety of educational efforts and immunization assessment activities to improve immunization rates in the City of Newark. Gateway is also the coordinating agency for the Newark Partnership for Lead Safe Children, which seeks to involve community-based agencies in the primary prevention of lead poisoning through reduction in environmental lead hazards. The BIMR Resource Center established through a grant to the Northern New Jersey MCHC has already been described.

The following is an illustration of a major accomplishment of just one of the MCHC this past year. The Northern MCHC in conjunction with the respective Healthy Mothers/Healthy Babies Coalition implemented the Irvington Family Development Center. This center offers pregnancy tests, vision, hearing, developmental and dental screening of children birth to six years of age, parental education and health education. The project receives funding from the Department of Human Services FACES initiative, United Way of Essex and West Hudson and the Department of Health and Senior Services. This project includes collaboration with the Urban League of Essex County, Newark Literacy Campaign, The Bridge, Inc., Programs for Parents, First Presbyterian Church of Irvington, and the Irvington Board of Education.

New Jersey's system of Maternal Mortality Review (MMR) was established in the late 1970s. In collaboration with a subcommittee of the Medical Society, the MMR was completed annually. However, the need to expand the MMR review team, utilize consistent case abstractions and complete reviews on a more timely basis was identified as a need by the Division last year. Using Florida's MMR system as a model, New Jersey began the task of revising our system. In collaboration with the Chair of the MMR subcommittee of the Medical Society, staff drafted a revised MMR protocol and presented the protocol to the full committee in May 1999. A request for proposals seeking to support the coordination of the MMR state activities and the

preparation of uniform abstracts was released by DHSS in the spring of 1999. The Central New Jersey MCHC was awarded the grant to implement the new system. Representatives from MCCH, the seven MCHC, and the Medical Society of New Jersey comprise the steering committee. The case review team membership was solicited from the seven MCHC and a variety of professional organizations throughout the state. It is expected that all 1999 maternal deaths using the current 90 day time interval for maternal deaths will be reviewed by the summer of 2000.

The Department has focused on efforts to decrease the rate of infants born at low birth weights (LBW). However, despite improvements in Neonatal Intensive Care Units (NICU) and community-base efforts that focus on early admissions to prenatal care and comprehensive services, we have not observed improvements in the rate of infants born at low birth weights. Overall trends in both low and very low birth weights indicate a small but steady increase in the number of infants born at these weights. A significant refinement in the reporting of LBW rates is the reporting of singleton LBW and singleton VLBW rates as Health Status Indicators. The rapid increase in multiple births due to assisted reproductive technology has influenced overall LBW and VLBW rates. Singleton LBW and singleton VLBW rates are stable or slightly decreasing (Appendix 4 Chart 4).

The percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates (Core Performance Measure #17) has increased through continuous quality improvement (CQI) activities which are coordinated on the regional level by the Maternal and Child Health Consortia (MCHC) Appendix 4 Chart 11. As part of the CQI program, the MCHC collect and analyze data on various perinatal and pediatric issues. The perinatal regulations require MCHC to collect data on and review all instances of infants born at very low birth weight and not delivered at facilities for high-risk deliveries. Based on the data analysis and review, the MCHC recommend, implement and monitor corrective action. The MCHC report CQI activities to the MCCH/Perinatal Health Services, which oversees and coordinates CQI activities statewide. The MCCH/Perinatal Health Services is reviewing CQI activities conducted by the MCHC in an effort to implement a standardized statewide approach to CQI. The plan is to

identify at least one common issue and implement a statewide quality assurance project to address this issue.

Another focus of CQI activities is the establishment of community-based fetal and infant mortality review (FIMR) teams (State Performance Measure (SPM) #3), which also impacts on the above Core Performance Measure. Currently three MCHC have FIMR teams. Over the next year the MCCH/Perinatal Health Services will be working with the remaining four MCHC to implement FIMR in their regions. Utilizing the American College of Obstetricians and Gynecologists (ACOG) NFIMR model. Perinatal Health Services staff continue to communicate with ACOG project staff and Dr. Ellen Hutchins for consultation and technical assistance.

Child Health staff has been participating in activities to coordinate and improve services for children with asthma (SPM #6), including issues of access. Staff have assisted the American Lung Association of New Jersey and the New Jersey Thoracic Society in creating a statewide Pediatric Asthma Coalition. They also assisted the Central New Jersey MCHC and the Gateway MCHC in forming regional pediatric asthma coalitions. Technical assistance was provided to these local coalitions in the preparation of applications for Robert Wood Johnson Foundation funding under the Allies Against Asthma initiative. The Newark coalition organized by Gateway has been selected as one of 26 finalists for these grants.

Special Child, and Adult Services and Early Intervention (SCAEIS) has greatly improved the accessibility of Children with Special Health Care Needs (CSHCN) to primary and specialty care (Core Performance Measure #11) through the support of Child and Adult Special Services and County Case Management Units. Health insurance data extrapolated from the combined CSHCN programs estimate that 6.0% of the 70,000 CSHCN served in 1999 were reported as uninsured. This compares with 7.2% uninsured in 1997. With the advent of KidCare to expand health insurance coverage, the percentage of uninsured CSHCN is anticipated to further decrease. Improvements in the reporting of insurance type is expected to reduce the percentage of unknowns from 3.6% in 1997. The County Case Management Units will continue to provide care coordination at no expense to families and to assist in referring families to resources such as

Medicaid, KidCare, the Catastrophic Illness in Children Relief Fund program, and the Charity Care program.

In 1997, SCAEIS expanded its health service grant with the Statewide Parents Advocacy Network (SPAN) to include a Parent-to-Parent Network and to further increase the degree to which the State ensures family participation in program and policy activities of the State CSHCN program (Core Performance Measure #14). The Parent-to-Parent Network links parents of CSHCN to “veteran” parents of children with similar needs for support, information on the disability, and problem solving. During 1999, nearly 60 volunteer support parents were trained and 125 matches were made. Projections for 2000 estimate an additional 150 parents will be trained and 150 matches made. The Statewide Family Voices Chapter, initiated by SCAEIS in collaboration with Family Voices and SPAN, is conducting family leadership development trainings. These trainings provide families with the information and support they need to advocate for their own children, advocate for and support other families, and advocate for improvements in policies, practices, and systems.

Accurate information on birth defects influences surveillance, service delivery, needs assessment, planning efforts and prevention. Birth defects affect 3-4% of newborns and are a leading cause of infant mortality. New Jersey has the oldest requirement in the nation for the reporting of children with birth defects. Beginning in 1928, New Jersey implemented reporting for children with orthopedic conditions. Since 1985, New Jersey has maintained a population-based Birth Defects Registry of children with all defects. This Registry supports the surveillance and service functions of CSHCN and children. The rules for birth defects have been repropose this year with only minor changes.

To improve the reporting of children with birth defects to the registry, annual audits are conducted by SCAEIS. All maternity and pediatric facilities are visited by SCAEIS staff and medical records are reviewed for children born within a three month period who have one or more congenital conditions, identified through ICD-9 codes in computerized records. Additionally, over the past year, staff have completed an extensive matching project, linking children in the Special Child Health Services Registry to birth certificate files. This linked data

set will support expanded data analysis of birth defects and special needs. State Performance Measure #7 will monitor the improvement of reporting children with birth defects to the Registry.

New Jersey was awarded a grant in September 1997 as one of eight national Centers for Birth Defects Research and Prevention. This grant award will greatly improve SCAEIS's infrastructure and information regarding potential risk factors associated with birth defects (State Performance Measure #8). While birth defects affect 3-4% of all newborns, the cause of 40-60% of birth defects is unknown. Participation in this national study will yield detailed information on potential risk factors for selected birth defects. Beginning in August 1998, the case-control study was implemented. In total, 400 interviews are to be completed each year, 300 with cases and 100 with controls. As of February 2000, more than 560 interviews have been completed. Memoranda of Agreement have been executed with various agencies to support implementation of local research projects, processing of DNA samples, and the initiation of a fetal abnormalities registry.

Data from the Birth Defects Registry is also being analyzed to support both State and national investigations as to the contribution of birth defects to infant mortality. Within the State, a summer 1999 Maternal Child Health Bureau graduate student matched infant deaths from the Registry and death files. Once the discrepancies from the files were resolved, the paper death certificates for those children with birth defects who had a non-congenital code of death were examined. The analysis will focus on cause of death and coding of the certificates. Staff from the Birth Defects Monitoring Unit are also examining differences between white and Black infants with congenital defects and characteristics of their mortality. On a national level, several states including New Jersey and the March of Dimes are collaborating on a project to investigate the mortality of children with birth defects and to describe any racial or ethnic differences.

III. REQUIREMENTS FOR APPLICATION [Section 505]

3.1 Needs Assessment of the Maternal and Child Health Population

3.1.1 Needs Assessment Process

The State has prepared the following statewide needs assessment that is required every five years and that identifies, consistent with health status goals and national health objectives, the need for: preventive and primary care services for pregnant women, mothers and infants; preventive and primary care services for children; and services for children with special health care needs.

The completion of a comprehensive needs assessment for the MCH population groups is a continual process that the Division of Family Health Services performs in collaboration with a number of other organizations. The methods and collaborative process will be discussed in the context of specific needs in the following sections for each of the three population groups - preventive and primary care services for pregnant women, mothers and infants; preventive and primary care services for children; and services for children with special health care needs.

Divisional and departmental strategic planning has been underway since December 1999. The development of strategic plans is an internal process to identify priority needs, establish performance measures, set annual targets and develop detailed annual plans. A FHS strategic plan including goals, objectives and strategies will be completed by June 2000. Many of the Healthy People 2000/2010 objectives and the MCH Block Grant Performance Measures are included in both the departmental and divisional plans.

In preparation for the annual State appropriations hearings FHS reviews and summaries programmatic initiatives, budgets, and emerging issues. Initiatives and budgets are justified in terms of standard health indicators and program evaluation data. This annual several month process takes place at the divisional level, then the departmental level, and finally is presented to the legislature.

Healthy New Jersey 2010 development has been a major departmental planning and needs assessment process that incorporates the MCH population. Establishment of an interdepartmental steering committee in January 1999 initiated the Healthy New Jersey 2010 development process. Representation included the Departments of Health and Senior Services, Environmental Protection, Human Services, Education, and Law and Public Safety. A divisional FHS subcommittee was formed to develop objectives for MCH areas which were covered in the chapters on Healthy Mothers and Young Children, Health Behaviors - Adolescents, Diabetes, and Asthma. The document identifies approximately 140 key indicators of the health status of New Jersey's residents, along with ambitious year 2010 targets for improvements. One of the overarching goals for improving the public's health is eliminating health disparities. A draft of the document was released in October of 1999 and public hearings in three sections of the state were scheduled in November. Updates on the status of Healthy NJ 2010 are available at the Department's website at www.state.nj.us/health/

Advisory groups and task forces provide valuable expert input, public and private constituency representation, and family member involvement into the MCH needs assessment process. Examples of key MCH advisory groups and task forces include: NJ Interagency Task Force on the Prevention of Lead Poisoning, Advisory Council on Adolescent Pregnancy, Medicaid Managed Care Alliance, Black Infant Mortality Reduction Advisory Council, and the Statewide Parent Advocacy Network (SPRANS) for CSHCN.

At the regional level the MCH Consortia conduct planning and needs assessment to promote a coordinated prevention-orientated approach to MCH services. Through regulations, each MCH Consortium must submit to the DHSS a regional perinatal and pediatric plan for approval, with projections for the following three years. The regional plans must address pediatric morbidity and mortality, risk-appropriate prenatal care, low birth weight, and teen births. The social, cultural, economic and demographic factors influencing the perinatal and pediatric needs of their communities must also be described. These plans serve as a guide for the MCH Consortium and its members in the development, coordination and evaluation of services for pregnant women, infants, children, and adolescents in the communities they serve.

The grant awarding, renewal and monitoring processes continually assess local needs that are area specific. FHS funds numerous grantees involved with MCH programs on a local level. The selection, renewal and monitoring of grantees is based on measurable outcomes, many of which are MCH block grant performance measures or Healthy People 2000 objectives. Examples of local grants include case management to assist primary health care providers through PORsCHE, and local planning and perinatal outreach through HM/HB Coalitions.

Surveillance and analysis of MCH data by the MCH Epidemiology Program is an ongoing process. The MCH Epidemiology Program produces standardized MCH health indicator reports, for FHS, for the MCH Consortia, and for other public health related organizations by special request. The MCH Epidemiology Program provides or collects all data needed for the MCH Block Grant. The MCH Epidemiology Program works with the Center for Health Statistics and the MCH Consortia Data/TQI Workgroup to support the data needs for regional planning. The MCH Epidemiology Program also conducts applied research projects which currently focused on issues related to multiple births, completeness of Newborn Biochemical Screening, smoking and pregnancy, and identification of risk factors for preterm birth.

Public comment on regulations and publications is an ongoing process of needs assessment and input from both public and private constituents. Rules implementing laws sunset every five years and therefore programs must readopt rules every five years. Proposed rules are published in the New Jersey Registry (NJR) with a 30-day open comment period. Responses to all public comment must be published, along with possible changes to the proposal before adoption of the rules (also published in the NJR).

These needs assessment processes take place continually and at times simultaneously. Specific needs are often addressed in separate processes and FHS staff is involved in coordinating the overall process. The various stages of comprehensive needs assessment such as priority setting, target setting, strategic planning, resource allocation, stakeholder collaboration

and re-evaluation are best described in reference to examples of specific needs as outlined in the following section.

3.1.2 Needs Assessment Content

3.1.2.1 Overview of the Maternal and Child Health Population's Health Status

Family Health Services has identified improving access to health services, reducing health disparities and increasing cultural competency as priority goals to address health service gaps and system constraints for the MCH population. Priority access to health service issues will be discussed further in relation to: increasing enrollment in NJ KidCare, coordinating the delivery of services to CSHCN through managed care, maintaining a safety-net of specialists for CSHCN, and access barriers to services for immigrant populations, especially pregnant women. Race and ethnic health disparities exist for most performance and outcome measures. The disparities in the key MCH areas of asthma, lead poisoning, prenatal care utilization, infant mortality, SIDS, homicide, and teen pregnancy will be discussed. Improving the cultural competency of services is another priority that crosses all MCH populations and all levels of the service delivery pyramid. Given the diverse cultural background of New Jersey's MCH population and the issues of access and disparities discussed above, the initial steps FHS has taken to improve the cultural competency of its services will be described.

The following table is an illustration of how the priority health goals of improving access to health services, reducing disparities in health outcomes, and increasing cultural competency of MCH services cut across all MCH population groups and all levels of the MCH service delivery pyramid.

PRIORITY GOALS	Population			Service Level			
	M & I	CHILD	CSHCN	DHS	ES	PBS	IB
Improving Access to Health Care							
Kid Care Enrollment	X	X	X		X	X	X
Immigrant Access	X	X	X	X	X		X
CSHCN & Safety Net			X	X	X		X
CSHCN & Managed Care			X		X		X
Reducing Health Disparities							
Asthma		X	X		X	X	X
Lead Poisoning	X	X	X		X	X	X
Infant Mortality	X		X		X	X	X
Low Birth Weight / Preterm	X		X		X	X	X
Teen Pregnancy	X	X		X	X		X
SIDS	X			X		X	X
Violence / Homicide		X			X		X
Increasing Cultural Competency							
FHS Staff	X	X	X	X	X	X	X
Grantee Staff	X	X	X	X	X		X
Health Providers	X	X	X	X	X		X

NOTE: M & I = Pregnant Women, Mothers, and Infants,

DHC = Direct Health Care, ES = Enabling Services, PBS = Population-Based Services,

IB = Infrastructure Building

Pregnant Women, Mothers, and Infants

Overall the majority of health measures concerning Title V as measured by Core Performance Measures, State Performance Measures, Outcome Measures and the new Health Status Indicators are stable or improving. The following section addresses the major health issue areas within MCH populations, highlighting relevant gaps in access to service, disparities in health indicators and cultural competency of services. Statewide ten-year trend charts for key Core Performance Measures, Outcome Measures, and Health Status Indicators mentioned in this section are presented in Appendix 4 (Charts 1-15).

For pregnant women measures of prenatal care utilization have improved slightly statewide for all major race/ethnic groups. First trimester initiation of prenatal care has been level while there have been encouraging recent increases in adequacy of prenatal care as measured by the Kotelchuck index and a decrease in no prenatal care (Charts 1,2,3). Although the relationship between prenatal care and pregnancy outcomes is very complex, timely prenatal care is necessary for early risk assessment to prevent or treat medical conditions, and for offering health behavior advice such as smoking cessation, breastfeeding, and nutrition counseling.

In 1998, the Division of Family Health Services discontinued funding for the provision of direct prenatal care services. With the expansion of Medicaid to 185% of the Federal Poverty Level for pregnant women and infants and the move to managed care for the Medicaid population, MCH supported agencies were receiving an average of 95% of their funding through Medicaid reimbursement. It was determined that scarce resources could no longer be utilized to supplement Medicaid. In 1999, support was provided to the existing network of prenatal providers for provision of enabling services to promote early entry into prenatal care and to ensure follow up to reduce infant mortality and low birth weight. The promotion of preconceptional health counseling was identified as a population-based service to reduce infant morbidity and mortality. To support local MCH planning and programs, FHS collaborates with the MCH Consortia, an established regionalized network of maternal and child health providers with emphasis on prevention and community-based activities.

The Services and Program subcommittee of the Black Infant Mortality Reduction Advisory Council submitted recommendations to the Department to encourage new concepts and innovative programs addressing gaps in services to Black women. The recommendations were used as a basis for the development of a competitive request for applications that was released in December of 1999. Applications were reviewed by a Review Committee, and awards to selected grantees are scheduled to be released by June 2000.

MCCH as the grantee for A Healthy Start for Essex County collaborated with the Camden HMHB/Healthy Start project in a partnership project to strengthen regionalized perinatal systems. Consumer empowerment sessions to improve perinatal service delivery were held in the target cities of Newark and Camden followed by a Summit in Central New Jersey entitled "Addressing the Gaps through Partnerships, an Initiative of Healthy Start". One hundred seventy consumers and stakeholders participated in the Summit. The empowerment sessions served as focus groups of consumers who identified strengths and weaknesses of the current perinatal system, challenges faced by consumers, and potential solutions to identified challenges. The summit partnered consumers with stakeholders to identify strategies and interventions to improve the perinatal system.

Areas highlighted during the empowerment sessions included education, system changes, community support, and provider changes. In the area of education, possible improvements involved increasing consumer education including health education, parenting skills, communication skills, family planning, stress management and GED programs, and increasing peer outreach/mentoring. In the area of system changes, possible improvements included increasing substance abuse counseling and residential treatment for pregnant women, and providing more stringent case management (i.e. reminders for check-ups, immunizations). In the area of community support, possible improvements included developing neighborhood networks to provide support through church, community and emphasizing family activities. In the area of provider changes possible improvements included improving the appointment processes to ensure efficiency and decrease patient frustration, providing sensitivity training for providers (attitude, cultural sensitivity), expanding services to more accessible hours and more locations,

and increasing length of stay in hospitals. The summit recommendations will be addressed in the next year with continuation of Healthy Start partnership funds.

To improve prenatal care services to prevent fetal alcohol syndrome (FAS) the MCCH and SCAEIS program are collaborating with the Department of Human Services. Through the Office of Prevention of Mental Retardation and Developmental Disabilities (OPMRDD), a FAS Task Force has been convened to assess and make recommendations regarding FAS prevention. Staff from both units participate on the task force, which is currently developing a white paper on the subject. MCCH hopes to use the task force report as a basis for modifying prevention programs and services to better reach women at risk.

The FAS risk reduction specialists screen, assess and refer perinatal clients for all substances including drugs, alcohol, and tobacco. Attempts to provide group smoking cessation programs have been unsuccessful. However, one-on-one counseling sessions have been successful in the area of smoking cessation.

Maternal smoking has been identified as a significant preventable risk factor for poor pregnancy outcomes. Additional analysis by the MCH Epidemiology Program is underway to identify risk factors and to target potential interventions. Implementation of a Pregnancy Risk Assessment Monitoring Survey (PRAMS) in collaboration with the department's Division of Addictions is planned. The implementation of PRAMS will be a very valuable surveillance tool for identifying additional and emerging perinatal needs.

Measures of low birth weight (LBW) and very low birth weight (VLBW) have increased since 1990. However, LBW rates and VLBW rates for singleton births as illustrated in Chart 4 are fairly stable or decreasing. The rise in multiple births, most likely driven by an increase in assisted reproduction, has markedly influenced overall rates of LBW, VLBW and prematurity. Multiple births greater than twins have increased over 500% since 1989. New methods of reporting LBW rates should be standardized to account for the rise in multiple pregnancies and multiple births due to developments in assisted reproductive technology.

The disparity in LBW rates by race and ethnicity are particularly concerning due to the role of birthweight in infant mortality and the long-term effects of LBW including neurologic disorders, learning disabilities, and delayed development (Chart 5). Given the multi-factorial nature of LBW, FHS has focused on improving services that are likely to influence LBW such as preconceptional care and early prenatal care.

Despite the overwhelming evidence supporting the numerous benefits of breastfeeding, breastfeeding rates in New Jersey have been relatively stable. Numerous collaborative initiatives are underway to promote breastfeeding and improve breastfeeding duration. Breastfeeding promotion activities have been funded statewide by the WIC program to MCH Consortia and local WIC agencies. Lactation consultants and peer counselors provide direct education and support services. Literature, education and breastfeeding aides including pumps are made available. Professional outreach and education are provided. New Jersey participated as a pilot state in the National Breastfeeding Promotion Project and was selected to send a team to the American Academy of Pediatrics Breastfeeding Coordinator's Conference in 1999. The team included representatives from WIC, the NJ Chapter of the American Academy of Pediatrics, the NJ Chapter of the American Academy of Family Physicians, and the NJ Chapter of the American College of Obstetrics and Gynecology. Using breastfeeding at hospital discharge data from the Electronic Birth Certificate, the group identified increasing exclusive breastfeeding initiation rates as a major objective. Breastfeeding rates at discharge by hospital varied inversely with the minority composition of mothers. Further examination of this disparity will require information of locally available breastfeeding promotional activities and the cultural competency of those services.

Teen pregnancy prevention is at the forefront in New Jersey. Teen Fertility rates by race and ethnicity are illustrated in Chart 6, and 14. Overall there has been a steady reduction in teen fertility for all race/ethnic groups. A description of initiatives to reduce teen pregnancy is presented in section 2.4. Family Health Services has been concerned about an upward trend in Hispanic teen births, which now appears to be reversing.

Infant Mortality Rates (IMR) have declined significantly in New Jersey since 1990. Chart 7 illustrates the decline in the neonatal mortality rate and the postneonatal mortality rate. The greatest decline in infant mortality appears to be in early neonatal mortality (Chart 8). Race and ethnic differences in IMR remain a major concern (Chart 9). Although all race/ethnic groups have experienced declines in IMR, the relative difference in rates between Black non-Hispanic and white non-Hispanic newborns, expressed as the ratio of Black to white IMRs, remains at 3.3 for preliminary 1998 data. The BIMR initiative and the current BIBS campaign target this disparity in infant mortality rates through public awareness campaigns and a provider education component. The HMHB Coalitions target the eleven cities with the highest infant mortality rates, low birth weight rates, and inadequate prenatal care rates. Two federally funded Healthy Start projects exist in Essex County and Camden.

Birthweight is one of the most important predictors of infant mortality. Birth weight-specific infant mortality rates are slightly better for black newborns in the very low birth weight categories (Chart 10), illustrating that the higher black IMR is due to a higher incidence of LBW. The higher risk for infant mortality among blacks compared to whites can also be attributed to higher risk of death among normal birthweight infants.

Analysis of birthweight and age-specific mortality demonstrates that the majority of infant deaths occur at very low birthweights and early ages. This analysis of fetal and infant mortality according to the World Health Organization's "Periods of Risk" approach is demonstrated in Chart 11. Birthweight-specific mortality rates and cause of infant death data (Chart 12) illustrate the role of LBW and prematurity while emphasizing the potential importance of preconceptual care and women's health. Studies of the underlying factors that contribute to infant mortality need to be conducted to develop effective strategies for the future. These studies must include efforts to explain not only the individual biologic factors, but also the social, environmental, economic and psychologic factors that contribute to infant deaths.

Disparities in race and ethnicity persist across most health indicators. Variation by geography is as great as between race and ethnic groups. Variation by municipality is influenced by community factors such as poverty, socioeconomic status, and the local health delivery

system. However, complete information on the underlying contribution of poverty, low socioeconomic status, poor education, and health behaviors are lacking to untangle their effects on health measures. Future improvements in the collection of health data at the individual level are necessary to begin to separate the social influences of poverty and the community from individual influences of biology and health behavior.

Issues related to preconceptual health care and women's health are being addressed through outreach and education programs sponsored by the MCHC and HM/HB Coalitions. Preconceptual health will be integrated with on-going MCH programs, conferences will be presented by the MCHC and HM/HB as well as joint projects with other agencies. Included in this Preconceptual Health Promotion Program will be a Folic Acid Initiative which will focus on preventing neural tube defects.

Important progress in reducing cause specific infant mortality has occurred in the area of Sudden Infant Death Syndrome. Following the introduction of the Back to Sleep Campaign the number of SIDS cases per year dropped by more than 30 in 1994. The rate of SIDS deaths now stands at .5/1000 in 1997, down from .9/1000 in 1994. Racial disparity in SIDS deaths persists and must be addressed through targeted educational efforts.

An important ongoing need assessment activity in infant mortality is the establishment of community-based fetal and infant mortality review (FIMR) teams utilizing the American College of Obstetricians and Gynecologists NFIMR model. Currently three MCHC have FIMR teams. Over the next year the MCCH/Perinatal Health Services will be working with the remaining four MCHC to implement FIMR in their regions. Utilizing a multidisciplinary case review process, FIMR and MMR identify gaps in systematic service delivery and make recommendations to improve linkages between community resources to enhance the system of care. Knowledge gained from FIMR and MMR will improve community resources and service delivery through the development of policy, resource and educational initiatives.

CHILD HEALTH

NJ estimates that there are over 150,000 children without health insurance. Improving access to preventive and primary care health services for children is a departmental and divisional priority. To provide comprehensive and affordable health insurance to eligible uninsured children, New Jersey and the Federal government have joined as partners in NJ KidCare. NJ KidCare, which is administered by the New Jersey Department of Human Services, started in 1998. By January 2000, over 67,000 previously uninsured children were enrolled. In July 1999, eligibility was expanded to include children in families with incomes up to 350 percent of the Federal Poverty Level, with a sliding scale for premiums ranging from \$15/family/month to \$100/family/month. The length of time these children must have been uninsured in order to be eligible was also reduced from twelve months to six months, unless coverage was terminated through no-fault (i.e. employer dropped coverage), in which case there is no waiting period.

In the course of developing NJ KidCare, the state learned that many poor children who are eligible for free health insurance under the state's Medicaid program are not enrolled in it. The aggressive marketing and outreach programs designed to enroll children in NJ KidCare are also being used to increase the number of children enrolled in Medicaid. If all children who are eligible for NJ KidCare or Medicaid enroll in these programs, then the percentage of children who are uninsured should drop to four percent. About half of ineligible children live in families with incomes over 350 percent of poverty; subsidized insurance is not available for this group, although consideration will be given to allow them to purchase coverage through NJ KidCare at full cost. The other half of ineligible children experience only temporary gaps in their insurance coverage, usually as a result of a change in a parent's employment. If employer-sponsored health insurance continues to decline, however, NJ KidCare will not be able to reduce the overall number of uninsured children in the state. For this reason, New Jersey wants to support, not compete with, employer-sponsored health insurance. By Executive Order, Governor Whitman created the Task Force on the Affordability and Accessibility of Health Care in New Jersey

in 1999. This Task Force will present its findings and recommendations on ways to make health insurance more affordable to New Jerseyans.

The MCCH Unit has collaborated with the NJ Department of Human Services (DHS), Office of NJ KidCare on the planning and development of a NJ KidCare Outreach and Enrollment Initiative. Under this initiative, the DHS has grants with the state's twelve Federally Qualified Health Centers (FQHCs) to conduct on-site KidCare enrollment activity. A total of one million dollars has been committed for a two-year project period. The FQHCs will identify potentially eligible children among the respective pediatric populations and assist interested families with the enrollment process. A similar initiative is in development involving the MCH Consortia, statewide WIC agencies and the Special Child Health County Case Management units. The Office of NJ KidCare has committed to a two-year, three million dollar project which is to be administered by the Department through grants to the above programs.

In addition to exploring ways to make health insurance more affordable and accessible, New Jersey continues to support a health care safety net. All New Jersey hospitals are required to provide needed care to patients, regardless of their ability to pay for this care. In return for hospitals fulfilling this obligation, the state continues its long-standing practice of contributing to the cost of this charity care, providing \$520 million in 1999 to charity care and hospital relief support to hospitals, as well as almost \$9 million to health centers that provide preventive and primary care to the uninsured. DHSS is working with several hospitals, including the leading providers of charity care in the state, to develop a demonstration program to provide charity care patients with primary and preventive care, using a managed care approach, to reduce their need for hospitalization.

In New Jersey, the geographic distribution of primary care providers including family practitioners, general pediatricians, obstetrician/gynecologists has improved somewhat. Recent primary care access reports indicate that New Jersey actually may be in jeopardy of losing many of our federally designated health professional shortage areas due to the Federal requirement that 30% of the population in a requested area be at or below 200% of the Federal Poverty Level. Many of the state's designations were approved prior to 1995 when the level of poverty required

was 20%. In addition, the enrollment of New Jersey's Medicaid eligible recipients into managed care and increasing provider capacity will also contribute to the loss of designations. FHS convened the Advisory Committee on Primary Care Areas in December 1999 to make recommendations on the designation of Rational Service Areas. Representation includes professional medical societies, Maternal and Child Health Consortia, HRSA Field Office Region II, and staff from the Bureau of Primary Health Care, Division of Shortage Designation.

The state has also instituted a State J-1 Visa Waiver program to meet the critical need for certain primary care providers in our most underserved areas. Dental care continues to be an area of concern. Although included as part of the managed care package, many of the state's underserved still have difficulty accessing dental services. FQHCs have continued to increase their capacity for providing dental services, but several still have significant waiting lists.

Financial access to health care is a necessary but not sufficient condition to ensuring true access to care. There are many barriers to access besides cost. Physicians or clinics may not be located in places where people can reach them easily, particularly people who lack private transportation. Office or clinic hours may not be convenient for people who are working or going to school. A lack of culturally competent care is of particular importance to eliminating health disparities. New Jersey is a highly diverse state and growing more so every year. It is important that all health care providers understand and value the cultures of their patients in order to better serve their health needs.

The Division of Family Health Services has developed and implemented a cultural competence training initiative. The Division's goal is to develop a seamless delivery system of culturally competent health care to the increasingly diverse citizens of New Jersey. The division formed a Family Health Services Diversity Team that was responsible for coordination and planning for the initiative. The first step in our plan was to offer and provide health service grantees with training that specifically addresses cultural sensitivity and competency within a health care delivery system. Those organizations and agencies that are supported with grant funds have had the opportunity to send staff to a Train-the-Trainer program so that they may share what is learned with their colleagues. In addition, increasing the numbers of members of

racial and ethnic minorities who pursue health careers should contribute to increasing the availability of culturally competent care. As part of its campaign to eliminate disparities in Black infant mortality, NJDHSS is working with partners to develop a standard curriculum that would enhance the cultural competency of providers working with Black women. This may prove to be a model that could be expanded to other cultural groups and providers.

Recent changes to immigration and welfare reform laws have generated widespread public confusion about whether legal immigrants receiving certain publicly funded benefits will be deemed to be a “public charge”, meaning they may be denied the ability to become legal permanent residents. This confusion and fear has deterred legal immigrant families from enrolling their children in Medicaid, NJ KidCare, WIC and food stamps. This confusion and fear has also deterred legal immigrants from receiving immunization and treatment for communicable disease, which places them, their families, and all residents at a public health risk.

In an effort to clarify “public charge,” two conferences were sponsored in New Jersey to assess the problem of implementing the May 1999 federal public charge guidance. The Southern New Jersey Perinatal Cooperative held a conference in the southern portion of the state on January 26, 2000. On March 26, 2000, Family Health Services, in collaboration with the U.S. Immigration and Naturalization Service, hosted a dialogue to examine the implementation of the guidance for northern region residents and to look at future collaborations to ensure access to services for eligible immigrant families.

Improving the collection of child health indicators is a priority for the next Block Grant cycle. State Systems Development Initiative funds are being used to support a Research Scientist position devoted to child health assessment and program evaluation activities. State priorities for child health assessment include immunization, lead poisoning, asthma, unintentional injuries, intentional injuries (violence, suicide), oral health, primary care, child care, adolescent pregnancy, and tobacco use.

In 1998, 85% of New Jersey's two-year olds received age-appropriate immunizations. In that same year, New Jersey recorded a total of 110 pediatric cases of vaccine-preventable illness.

Efforts to increase the percentage of children immunized are focused on urban areas with historically low immunization rates, particularly Newark.

New Jersey has required the reporting of lead poisoning in children since 1975. In 1999, 1,604 children were reported to the department as having blood lead levels ≥ 20 ug/dl (see Chart 13). While there were children reported with lead poisoning from every county, the majority of these children are from minority groups living in poverty in the State's major urban centers. Over one-fourth of affected children resided in Newark. The DHSS maintains a data system to receive elevated blood lead reports from laboratories and to notify local health departments, who are required by State law to investigate every case of lead poisoning and to order the remediation of any environmental lead hazards found. As of July 1999, laboratories are required to report the results of all blood lead tests to the DHSS. The information will enable the department to monitor compliance with the State law requiring lead screening of all children and to better target prevention activities to the areas of greatest need. Adoption of universal lead testing results and development of the lead surveillance system will permit accurate local assessments of lead poisoning.

National data have identified asthma as the most common chronic disease in children. Asthma is responsible for over 500,000 hospitalizations and 5,000 deaths each year nationwide. However, New Jersey specific data on asthma is limited. Using preliminary, hospital discharge and death certificate data from 1998, the MCH Epidemiology Program identified 10,677 hospitalizations and 7 deaths in New Jersey due to asthma among persons under 20 years of age. Of these, 36% of the children hospitalized for asthma were black, double the percentage of black persons in the population. In addition to routine monitoring of mortality and hospitalization data, one means being explored is use of the Children with Special Health Care Needs Registry. Asthma is already a condition for which voluntary registration is accepted, but less than 3,000 children are currently registered.

New Jersey ranks 50th among the states in the percentage of the population receiving water with optional fluoridation. In response to this, an emphasis has been placed on individual actions by parents and children to prevent tooth decay, including fluoride mouth rinses and

supplements, dental sealants, tooth brushing, and nutrition education. These programs are described in more detail in section 2.4.

Efforts to identify the needs of adolescents are ongoing. An Adolescent Health Profile was published in 1998. An Interagency Adolescent Health Team continues to monitor trends and an updated Profile is planned for 2001. There is, however, clear evidence that to improve the health status of the adolescent population and to decrease mortality and morbidity, efforts must increase to reduce adolescent risk-taking behavior. The strategies to be employed are not limited to enabling services but must include approaches that touch all levels of the MCH services pyramid. For the pregnant or parenting teen, supportive home visitation services seek to improve a teen's parenting skills, encourage healthy lifestyle choices, and ensure that the infant and mother get the health, educational, and social services needed.

Unintentional injury continues to be the number one contributor to child mortality in the 1-4 and 15-24 year populations. Motor vehicle crashes are the leading cause of mortality in youth 10-21 years of age. Unintentional injury, specifically drownings, disproportionally affect black youth age 10-21 years, who account for 50% of drowning deaths.

Homicide is the leading cause of death in black youth, and is the second leading cause among all youth 10 - 21 years of age, with 67% attributed to firearms. New Jersey's suicide rate among youth is lower than for youth in the United States in general, yet it is the third leading cause of death in New Jersey youth 10-21 years of age. Developing effective interventions to reduce cause specific mortality for youth is needed, as well as addressing underlying root causes of mortality such as risk-taking, substance abuse and violence.

To reduce teen pregnancies, family planning agencies throughout the State have linked with school health programs to provide outreach and education to students. Outreach and education is a significant part of all grantee Family Planning Programs. These programs work closely with local school districts and the School Based Youth Services Programs in DHS. The type and amount of participation is very much dependent on the needs and desires of the local community. DHSS and DHS staff continue to collaborate on a grant initiation from the Dodge

Foundation in providing support, development and implementation of training sessions for educators, youth counselors and family planning providers on the most effective strategies, teaching methods and systems of coordination, whose purpose is to reduce pregnancies among adolescents and assist in managing their sexual behavior responsibly.

In 1995, almost 40% of high school students in New Jersey reported using cigarettes. The percentage of students who smoked in 1995 did not decrease significantly from 1980 levels, and actually increased from 1989. The 1999 Middle School Survey found 38% of sixth to eighth grades had ever tried cigarettes, and 13% smoked in the past 30 days. The Division of Addiction Services plans to conduct the Youth Tobacco Surveillance Survey to collect statewide data on knowledge, attitudes and behaviors of youth regarding tobacco. An anti-tobacco media a public relations campaign focusing on middle school youth titled, "Don't Get Sucked In" is already underway to decrease youth initiation of tobacco.

Staff from the Child and Adolescent Program work cooperatively with the Division of Addition Services on initiatives to reduce adolescent tobacco use. Our staff have actively participated on the CDC Tobacco Control Advisory Panel. This advisory panel provides structure and guidance to regional coalitions throughout the state who implement tobacco prevention programs at the local level. The prevention Dental Education Program targets tobacco prevention in its oral health education for middle school students. The curriculum "Mr. Gross Mouth" discusses the oral health problems of oral cancer and gum disease associated with smoking and chewing tobacco. As part of the Family Planning Program's Adolescent Enhanced Service Program, assessment education and follow up regarding the risk of smoking are routinely provided to participating teens.

By implementing more risk reduction programs at the local level for the adolescent population, chances will increase for reducing the adverse consequences often associated with risk taking behavior: unintended pregnancies, STDs, intentional and unintentional injuries, poor nutrition, and substance abuse. The Child and Adolescent Health Program will continue to strengthen coordination and linkages with school based youth services programs, and improve interagency communication so that limited resources can be combined to

promote comprehensive services. Community Partnerships for Healthy Adolescents continues to promote the development of an integrated prevention-oriented, risk reduction service delivery system for adolescents at the community level.

Children with Special Health Care Needs

Numerous data sources exist within CSHCN to provide information on needs assessment. A first step in conducting or assessing needs is establishing the extent of need and defining the target population and subpopulations of interest. The Special Child Health Services Registry is a confidential, unduplicated database comprised of two components: Birth Defects and Special Needs. Children with birth defects are required by statute and regulation to be reported to the department, and as such, can be considered to be a census of affected children. While there is no mandate to register children in the Special Needs component, the department receives nearly 5,000 registrations annually for children who have other conditions that may require service intervention. This portion represents the minimum number of affected children with such conditions.

Activity reports are submitted quarterly by case management units as well as the Specialized Pediatric network agencies and grantees. These reports are used to determine health services indicators and utilization measures. Within Newborn Biochemical Screening, the program keeps detailed records on the number of children followed for each disorder, and the number of confirmed diagnoses.

Each year, nearly 9,000 children are newly reported to the Special Child Health Services (SCHS) Registry. Of these, about half are registered with one or more birth defects while the remaining children have other at-risk or special needs conditions. Reports to the Registry include all newborns diagnosed with metabolic disorders as well as infants and children diagnosed with hearing loss. Between 1993-1994, the rate of birth defects in New Jersey was 34.5 per 1000 live births, consistent with national data. Nearly 70% of the children with birth defects and 66% of children with special needs are reported before their third month of life. As

compared to birth data, more males than females are registered with both birth defects and special needs conditions.

Racial data contained in the SCHS Registry had historically included a high percentage of “unknowns,” affecting the accuracy of data analysis. Since 1998, staff from the Birth Defects Monitoring Program have been working to link children reported to the SCHS Registry to birth certificate files. The linking has been completed for birth years 1992-1997. This matched dataset now provides more accurate information on the racial characteristics of the children. The racial composition of children born 1992-1997 with one or more birth defects is 70.0% white, 21% Black, 8.0% other, and less than 1% unknown, compared to the New Jersey birth distribution of 74.7% white, 19.0% black, 3.6% other and 2.7% unknown.

Data from death certificates indicate that congenital anomalies are the leading cause of infant mortality. In 1996, 133 of the 792 infant deaths were due to congenital anomalies. Of the 133 infant deaths due to congenital anomalies, 93 were white infants and 38 were Black infants. Additionally, in 1996, congenital anomalies and malignant neoplasms were tied for the leading cause of deaths among children age 1-4, and congenital anomalies were the fifth leading cause of mortality among children age 5-14. Overall, in 1996, congenital anomalies were the 8th and 6th leading cause of years of potential life lost before age 65 in men and women, respectively, in New Jersey.

However, children with congenital defects also die from other causes. Data from the SCHS Registry indicate that of the 25,579 children born 1992-1997 and registered with one or more birth defects, 5.6% expired by age one. Birthweight has a profound effect on the mortality of children with birth defects. Whereas nearly 70 percent of children weighing less than 500 grams died within their first year of life, the percentage drops to 24% for children 500-999 grams, 10% for children 1000-2500 grams and 3% for those weighing more than 2500 grams. Within each of the four weight categories, the mortality across racial groups is nearly the same. However, in a preliminary analysis of defect specific mortality, there does appear that some racial differences are present. For example, for children with Down syndrome, there are no racial differences seen in the mortality for those newborns weighing less than 999 grams. For

newborns with Down syndrome weighing 1000-2500 grams, black newborns are nearly three times as likely to die within the first year of life than white newborns. Staff from the Birth Defects Monitoring Program have just begun to investigate this and other defect specific mortality with racial differences.

During 1992-1997, most children were registered with defects of the heart, great veins and conduction (n=8,885), followed by external/internal genital anomalies (n=3,412), musculoskeletal system defects (n=3,308), and digestive system disorders (n=2,206). Each year in New Jersey, more than 100 children are born with Down syndrome, one of five major heart defects (common truncus, transposition of the great vessels, tetralogy of fallot, hypoplastic left heart, and total anomalous pulmonary venous return), and oral clefts.

The SCHS Registry serves as the primary entry into the local, community-based case management system. For children who are still alive at time of registration, a copy of the registration form is forwarded to the case management unit in the county of residence of the child. This includes all children with both metabolic disorders, hearing impairment, other birth defects, and special needs. Compared to other states, this direct link from the surveillance system to the service delivery system is unique. It is both highly effective and cost efficient, and serves as a means of quickly identifying children with special health care needs who may require service intervention. Since nearly 70% of all children are reported to the Registry by three months of age, families receive timely support and information for their children.

The timely linkage of the surveillance and service systems is particularly useful for the Early Intervention System (EIS). Currently, the EIS identifies 10 conditions that constitute “presumptive eligibility.” These 10 conditions include: Down syndrome, fetal alcohol syndrome, hearing impairment, vision impairment, autism/PDD, spina bifida, cerebral palsy, trisomies (e.g. 13,18), fragile X syndrome and hydrocephalus. Children presenting with one or more of these conditions are eligible, by virtue of their diagnosis, to receive early intervention services. A recent data analysis was performed to determine the timeliness of identification of children with these disorders. Using data from the Registry, the age at registration was calculated for the 10 disorders. The results of the analysis show that for all of the conditions,

57% of the children were registered before three months of age, and 81% before age one. For some of the conditions readily identifiable at birth, such as Down syndrome, Trisomy 13, Trisomy 18, other chromosomal disorders, and spina bifida, nearly 80% of children were registered by three months and over 95% before age one. The data support the usefulness of linking surveillance to service delivery.

Improvements in the reporting and tracking of newborn screening programs are evident in the Newborn Biochemical Screening Program and the Newborn Hearing Program. Record linkage between the Electronic Birth Certificates and the Newborn Biochemical Screening files clearly demonstrated that more than 99.7% of infants born in New Jersey are screened for biochemical defects. The reporting of Health Status Indicator (Newborn Hearing Screening) demonstrates the rapid increase in newborn hearing screening to 41% of 1999 births. New Jersey birthing facilities must establish guidelines for follow-up for newborns identified with or at risk for developing hearing loss. Follow-up services must include but are not limited to: 1) confirmatory pediatric audiological assessment, 2) diagnosis of newborns with abnormal or inconclusive test results, 3) submissions of Newborn Hearing Follow-up Report, 4) counseling and educational services for parents, guardians or custodians, 5) explanation of potential effects of hearing loss on development of speech, language, and/or cognitive skills, 6) potential benefits of early identification and intervention.

The Newborn Biochemical Screening Follow-up Program (NBSFP) is responsible for the follow-up of all newborns with “not normal” metabolic screening results. Approximately 1,600 newborns have initial “not normal” results on one or more of the four screening tests performed. Of these, approximately 10% are found to have a classical or variant form of the disorder. Additionally, approximately 2,800 newborns are found to have sickle cell trait and to be carriers of the sickle cell gene. Although these newborns required no treatment intervention, the Follow-up Program provides information to the families of these newborns.

Each month, the Newborn Biochemical Screening Follow-up Program issues a “turnaround time” tracking report which documents how old the newborns with initial presumptive-positive results were when their screening results were received by NBSFP and

reported to the physician of record. Presumptive positives are those screens whose results are highly abnormal. The accepted protocol between the laboratory and the NBSFP is that these results will be available for newborns by age 13 days. From June 1999-February 2000, 367 presumptive positive results were received. Of these, 8.7% (n=32) exceeded the 13 day protocol. This data provides critical information to both the follow-up and laboratory programs.

The NBSFP also monitors the age at which newborns with confirmed disease are seen by a physician. This data is useful for laboratory and program staff, as well as the consultants for the disorders, for quality control and clinical management issues. For example, in 1998, 35 newborns were confirmed to have congenital hypothyroidism. Of these, 31 were in treatment before age 21 days, which is the national standard. The remaining four infants were seen at ages 48, 52, 57, and 105 days respectively. For these four infants, the consultants and NBSFP staff determined the reasons for delay and reviewed if procedures need to be changed. This process provides a continuous review of follow-up procedures and medical involvement.

Since the SCHS Registry is a crucial database serving epidemiological, research, linkage to service delivery, and other public health functions, it is critical that the database be complete and accurate. To meet this requirement, a comprehensive quality assurance program has been implemented. Each year, a quality control audit is completed at each maternity and pediatric facility. During these audits, the medical records for a three-month period of births are reviewed and compared to the information in the Registry. This review provides information on the number of children not registered and compares the accuracy of the information provided on the registration form. Upon the conclusion of the audit, a summation meeting is held between Registry staff and representatives of the facility, followed by a written report. Data from these audits indicate that 85-90% of children with birth defects is appropriately reported.

In addition to the audits, other steps have been taken to improve the Registry. As described earlier, linking the Registry to birth certificates expands the information available on each child. Death certificates are reviewed, to ensure complete mortality data, as well as for case finding. The newborn hearing and newborn biochemical screening programs provide reports to

the Registry, and are thus linked through the Registry. The database is continuously “cleaned” for duplicates, valid ranges, and logical consistency.

Advisory groups play an important role in providing professional expertise in the area of newborn biochemical screening. Under current statute and regulation, newborns are screened for four metabolic disorders: phenylketonuria, galactosemia, congenital hypothyroidism, and hemoglobinopathies, including sickle cell disease. For each of these disorders, semi-annual meetings are held with the consultant groups, which are comprised of a wide range of medical specialists and other health care providers involved in the diagnosis and management of the disorders. The purpose of the consultant meeting is to ensure that testing and follow-up procedures used by the state are reflective of best medical and laboratory practices. For example, the galactosemia consultant group is working to develop consistent treatment guidelines for newborns diagnosed with the d/g variant. The hyperthyroid consultant group initiated a laboratory research project to investigate delayed onset of hypothyroidism in premature infants. As a result, serial testing is now performed to provide more accurate screening results for premature newborns. Additionally, the medical consultants represent the concerns of the families with affected newborns, including such diverse issues as insurance reimbursement, obtaining referrals for appropriate pediatric medical consultants, and identification of unmet needs.

The new Advisory Panel on Newborn Screening will convene April 2000. The purpose of this panel will be to review current newborn screening tests and to make recommendations for screening for additional disorders. Over the past year, the department has received both public and professional inquiry about expanding the screening to include cystic fibrosis, maple syrup urine disease, medium chain acyl-coA dehydrogenase (MCAD) deficiency, congenital adrenal hyperplasia, and other disorders that can be detected and treated. As part of this process, the panel will include focus groups to be held with parents of both affected and unaffected newborns.

In New Jersey, the rules implementing laws sunset every five years. As such, programs must review and readopt the rules every five years. During 1999, the rules implementing

mandated reporting of children with birth defects as well as both newborn hearing and newborn biochemical screening were reviewed. As part of the readoption process, the rules are published in the New Jersey Register, and a 30-day open comment period is set after the initial publication. Programs also are required to alert interested parties about the readoption and the public comment period. At the close of the public comment period, the department is required to address all comments, and publish the answers as part of the final readoption.

During the readoption of the birth defect rules, over 125 letters were mailed to hospitals, case management units, the MCH Consortia, and other agencies informing them of the readoption process. As a result, four comments were received. All letters supported the need for the Birth Defects Registry, recognizing its necessity for public health surveillance and research related to the occurrence and incidence of birth defects. Three letters encouraged the department to explore the feasibility of using the electronic birth certificate to replace manual reporting. Unfortunately, there is both national data and state data to confirm that the birth defect information is not accurately or completely reported on birth certificates. For example, in New Jersey for both 1996 and 1997, fewer than half of the birth certificates of children reported with Down syndrome to the Registry contained the Down syndrome diagnosis. The remaining letter focused on the importance of physician involvement in the diagnosis and management of children with birth defects, and questioned whether advanced practice nurses can make or confirm the diagnosis of a birth defect. In New Jersey, State law permits management of specific common deviations from wellness by advanced practice nurses, including initiating laboratory and other diagnostic tests.

During the readoption of the Newborn Biochemical Screening rules, over 5,600 letters were mailed to hospitals, physicians, case management units, the MCH Consortia and other agencies informing them of the readoption. Ten comments were received, which focused on two areas: the diseases included in the screening panel and which laboratory can perform the testing. In December 1999, the department decided to convene the Advisory Panel on Newborn Screening to specifically review the disorders included in the screening and to make recommendations to the Commissioner. To ensure that no newborns are missed, the system of newborn screening must be seamless. As such, the department decided to continue having only

the public health laboratory conduct the required newborn screening panel. No such limitation exists for tests performed for other disorders.

Following the publications of the proposal for readoption with amendments of the rules for the New Jersey Newborn Hearing Program (N.J.A.C. 8:19, Subchapter One), seven comment letters were received, all supporting universal newborn hearing screening using electrophysiological measures. Other areas addressed included the need for monitoring compliance, identification of data, and mandating insurance reimbursement for newborn hearing screening.

Ongoing efforts are made by SCAEIS to support agencies providing direct specialty and sub-specialty services for CSHCN. Although KidCare has expanded its eligibility criteria, KidCare contracts with managed care organizations that reimburse for primary care. Obtaining referrals from HMOs for comprehensive specialty care has been reported by parents as tedious, time consuming and often too complex. Reimbursement rates for specialty care are far below the costs for services. The program is working with the provider agencies to improve data collection, clearly define the information that is needed from them, and establish consistency among the agencies. One goal is to document the difficulties the specialty clinics have in making services accessible and available to families. Another goal is to demonstrate the increase in referrals for certain conditions, especially in the areas of learning and behavior.

Managed Care benefits packages typically recognize the services of one or two specialists who are only part of a comprehensive team of specialists required to accurately evaluate and treat CSHCN. Historically, care coordination has been provided by the sub-specialty teams collaborating with primary care providers, SCHS County Case Managers, school districts, Early Intervention Programs, DYFS, and other involved agencies. Reimbursement for team care is only a fraction of the real cost for this service.

Decreased availability of specialty care for CSHCN of lower income families is noteworthy in some areas. In the past decade increased numbers of children experiencing developmental problems in the areas of learning and behavior have been noted (e.g., autism and

ADHD). School child study teams do not usually have the expertise to evaluate and diagnose these problems because of lack of medical and behavioral specialists. Without timely intervention, children begin a rapid cycle of educational and social difficulties which may lead to school drop-out and/or involvement with the juvenile justice system. Numbers of reports of violence and other criminal behaviors by juveniles in the school and community have increased. There is desperate need for adequate resources for early diagnoses and development of intervention strategies.

Through a network of Child Evaluation Centers (CECs) providing comprehensive evaluations and suggested intervention strategies, attempts to enhance Child Study Team determinations are made. State funded CECs are encouraged to collaborate with school systems to promote the welfare of special needs children. However, extremely low reimbursement levels for specialty care (comprehensive team evaluation and treatment) have impacted negatively on the ability of specialty and rehabilitation care to provide quality services.

Currently, a competitive process for funding Child Evaluation Centers is underway. There is limited funding for these providers and the need for services is indicated by submission of over twice as many applications as are currently funded. Many of the target population for Child Evaluation Centers are those children whose needs are too complex for the school system to adequately assess and develop intervention strategies. If diagnoses are not accurate and treatment is not provided for these children, their problems will escalate quickly with sometimes disastrous results for themselves, their families, the community, and society as a whole.

In recognition of the importance of folic acid in reducing neural tube defects, the Department has partnered with the New Jersey Folic Acid Coalition as described in Section 1.5.2. Some recent activities of the Coalition have been the formation of a speaker's bureau, ensuring that the folic acid message is included in a broader array of consumer/professional meetings, and the initial stages of developing training modules for a variety of health professionals.

In 1997, SCAEIS expanded its health service grant with the Statewide Parents Advocacy Network (SPAN) to include a Parent-to-Parent Network and to further increase the degree to which the State ensures family participation in program and policy activities in the State CSHCN program (Core Performance Measure #14). The Parent-to-Parent Network links parents of CSHCN to “veteran” parents of children with similar needs for support, information on the disability, and problem solving. The Statewide Family Voices Chapter, initiated by SCAEIS in collaboration with Family Voices and SPAN, is conducting family leadership development trainings. These trainings provide families with the information and support they need to advocate for their own children; advocate for and support other families; and advocate for improvements in policies, practices, and systems.

3.1.2.2 Direct Health Care Service and Enabling Services

3.1.2.3 Enabling Services

The priority State concerns regarding access to direct health care and enabling services will be presented in this combined section. As outlined in Section 3.1.2.1, Overview of the Maternal Child Health Population’s Health Status, and detailed for the three MCH population groups in the previous section, priority goals for FHS are improving access to health services, reducing racial and ethnic health disparities, and increasing cultural competency of MCH services.

Fiscal barriers for pregnant women, mothers and infants has been reduced through Medicaid expansion and NJ KidCare to promote access to primary care and preventive direct services. Further enrollment of children and possibly whole families through FamilyCare will further reduce fiscal barriers to primary care. The need for enabling services will continue to be a priority with many of the financial barriers being removed for mothers, children and adolescents seeking primary health care services. Enabling services for pregnant women, mothers and infants provided through MCCH supported programs include the Healthy Mothers/Healthy Babies programs, the Maternal and Child Health Consortia, HealthStart, and Healthy Start. Coordination efforts will continue with Medicaid and focus on implementing the NJ KidCare initiative and quality assurance standards for preventive and primary care services

for mothers, children and adolescents. Issues of availability of primary care services were described in the previous section concerning the redesignation of Rational Service Areas and MCH Consortia regional planning. Improving the cultural competency of MCH direct and enabling services was addressed as well in the previous section.

The fiscal barriers for CSHCN to access services have been reduced by subsidized direct specialty and subspecialty services. Through a recent national survey with Family Voices and Brandeis University, SCAEIS gained valuable information about families' needs and experiences with health care including the kind of health coverage used, the frequency and type of service used, problems in access and coordination between agencies. The degree of change in the availability of primary care services for CSHCN with the implementation of KidCare and Medicaid Managed Care is uncertain. Since a number of children receiving services through county case management units still have difficulty accessing health care services and are ineligible for KidCare and Medicaid due to income eligibility, SCAEIS will maintain its safety net of direct specialty services for CSHCN through its network of providers. The County Case Management Units will continue to assist families in identifying financial and insurance resources while providing referrals to primary care and specialty services.

3.1.2.4 Population-Based Services

The essential population-based services provided by the state are the Newborn Biochemical Screening, Lead Screening, Newborn Hearing Screening, and Immunizations Programs. Other population-based services are the SIDS Center of New Jersey, the Black Infants Better Survival awareness campaign, injury prevention programs, physical fitness and nutrition programs, the school fluoride mouth rinse program, and oral health education programs.

In the area of Newborn Biochemical Screening current needs concern the addition of new screening tests. Testing, reporting and follow up are all directly managed by the State and are available statewide. As genetic tests are perfected, it is possible to screen for more newborn biochemical disorders. Since there are no national standards concerning which disorders to include in a screening panel, states are faced with balancing the new technologies into the system

of newborn screening. More than just laboratory tests, the system must be able to follow, treat, and influence clinical outcomes. To address these changes and concerns, the Advisory Panel on Newborn Screening will be convened April 2000.

In 1999, 41% of newborns were screened for hearing loss prior to hospital discharge. The number of newborns receiving hearing screening continues to increase as more hospitals adopt universal screening policies. Amended regulations that will take effect in 2002 require all birthing facilities to screen all newborns prior to discharge or before one month of age. The tracking and follow up of identified newborns with hearing loss through existing case management and Early Intervention Services is necessary to ensure appropriate provision of services.

DHSS maintains a lead surveillance system to receive blood lead reports from laboratories and to notify local health departments who are required to follow up individual children. As of July 1999, laboratories are required to report all blood level tests to the DHSS. Universal lead testing reporting will provide accurate local assessment of lead poisoning and permit targeted prevention activities. Further collaboration with local organizations such as the Newark Partnership for Lead Safe Children will be needed to move from identification and treatment of lead poisoned children to primary prevention of lead poisoning.

The New Jersey Immunization Information System (NJIS) is an electronic repository of information on the immunization status of children, designed to improve immunization tracking and increase immunization rates. The system has been installed at 99 sites and is currently being expanded. The Immunization Program in the Division of Communicable Diseases supports population-based services through NJIS, annual immunization surveys, providing technical assistance to local health departments and schools, implementing the Vaccine For Children Program, and providing vaccines to public sector providers. Further use of population-based data, identification of barriers to complete immunization, and reduction of missed opportunities to immunize are needed to increase existing immunization rates.

FHS has recognized and responded to the need for statewide population-based educational services such as the SIDS Center of New Jersey and the Black Infants Better Survival (BIBS) campaign. Information on FHS programs as well as referral services to MCCH programs are available statewide through the toll-free Family Health Line telephone. The need for local population-based services such as oral health education programs, school fluoride mouth rinse programs, and injury prevention programs has already been described in section 2.4. FHS will expand those population-based programs and other model programs which have been shown to be effective.

3.1.2.5 Infrastructure Building Services

FHS promotes comprehensive systems of services for the MCH population by continually assessing statewide needs, identifying priority needs, developing strategic plans, collaborating with other agencies and allocating resources to meet targets. A full description of the Needs Assessment Process is provided in section 3.1.1. Collaborative efforts to promote comprehensive systems of care are described in Section 1.5.2, State Agency Coordination. Existing collaboration processes were discussed for key MCH areas for the three MCH population groups. Identified area specific needs including local and regional areas are discussed in the Needs Assessment Content section 3.1.2.

Areas of improvement within the general needs assessment process concern improving data systems, increasing interdepartmental coordination and increasing collaboration with local delivery systems. Identified priority needs must be communicated to all involved agencies and incorporated into target setting and strategic plan development. Because most MCH issues overlap with those of other departments and agencies, definitions and measures of priorities and their targets must be standardized. MCH Block Grant Performance Measures and Healthy People 2000/2010 objectives are a means of standardizing needs, defining targets and promoting the development of strategic plans that can be used and understood across departments and agencies.

In the area of infrastructure and promoting comprehensive systems of services, FHS recognizes the need to improve and integrate its information systems. Existing population-based data sets need to be integrated to create a system of MCH related information. This integrated data system would be extremely valuable in future assessments and evaluation of priorities and programs. Currently the NJDHSS is implementing the design of a department-wide integrated information system. FHS staff was involved in the development of a Logical Data Model and Business Intelligence Plan. For the short term, FHS is anticipating the implementation this summer of a Pregnancy Risk Assessment Monitoring Survey (PRAMS) survey in collaboration with the Division of Addiction Services. PRAMS would provide valuable information for the planning and evaluation of perinatal programs.

In the area of promoting comprehensive systems of services and local delivery systems, FHS collaborates with the MCH Consortia and local health departments on a number of MCH issues. The greatest need is to continually assess the service capacity and service needs at the local level. As mentioned in section 2.4, the Advisory Committee on Primary Care Areas convened by FHS is charged with assessing primary care access and designating Rational Service Areas to be used in identifying health professional shortage areas and medically underserved areas. Information on local service delivery and service resources needs to be made accessible, so that local planning efforts are successful and accurate.

In the area of infrastructure building services and developing approaches to the evaluation of care systems, FHS is working to improve perinatal services through the Maternal Mortality Review and Fetal Infant Mortality Review Team process. As described in section 2.4, the infrastructure needed to address issues of perinatal services is being revised and expanded.

In the area of quality of care FHS has recognized the need to promote standards of care in a number of areas including lead assessment and treatment, subspecialty services of CSHCN, and comprehensive perinatal care guidelines for Health Start services. The future development of standards of care in specific clinical areas are most appropriately addressed by the specific advisory groups.

The department collaborates with various other state agencies and private organizations to promote a comprehensive system of services of its CSHCN populations. SCAEIS works with parent groups, specialty providers and a statewide network of case managers to provide family-centered, community-based, coordinated care for CSHCN. SCAEIS collaboration with other agencies is described in section 1.5.2 State Agency Coordination. Recent issues concerning managed care and CSHCN have brought together the Office of Managed Care in DHS, parents, advocate groups, and HMO case managers to assist CSHCN families navigate the managed care system.

3.2 Health Status Indicators

During the past two years the MCH Bureau and states have identified a set of MCH-related health status indicators that states would report annually. These health status indicators represent practical, highly prevalent, and prevention-oriented data and elements common to the findings in the majority of states' needs assessments. Core health status and developmental health status indicators are summarized in Section 5.4 and 5.6.

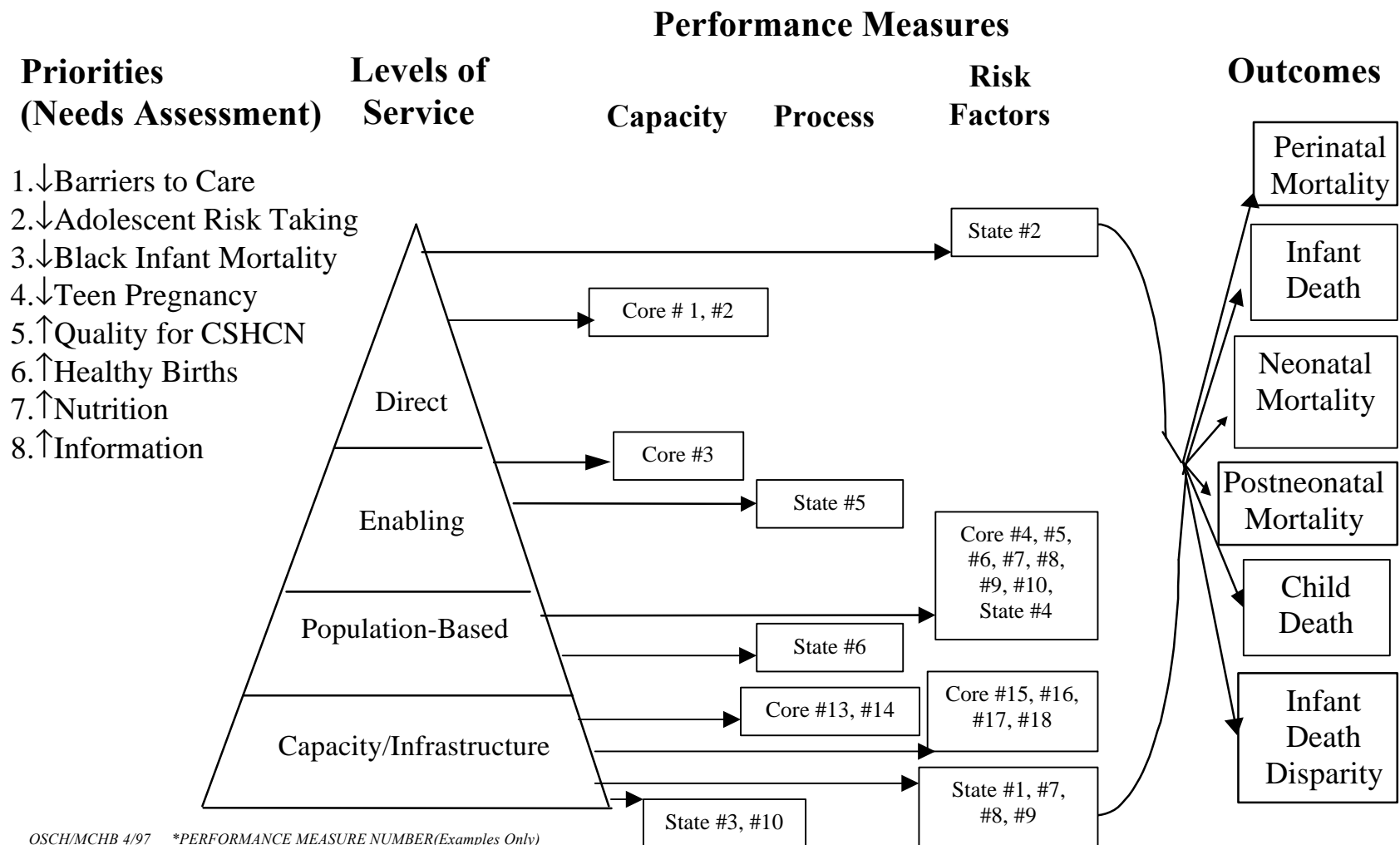
3.2.1 Priority Needs

Identified priority needs are listed below and included on Figure #3.

1. Improving Access To and Utilization of Preventive and Primary Care Health Services
(↓ Barriers to Care)
2. Reduction of Adolescent Risk Taking Behaviors
(↓ Adolescent Risk Taking)
3. Reducing Black Infant Mortality
(↓ Black Infant Mortality)
4. Reducing Teen Pregnancy
(↓ Teen Pregnancy)
5. Improving Access to Quality Care for CSHCN
(↑ Quality Care for CSHCN)
6. Increasing Healthy Births
(↑ Healthy Births)
7. Improving Nutrition and Physical Fitness
(↑ Nutrition)
8. Decrease hospitalizations for ambulatory sensitive conditions, specifically asthma
(↓ Preventable Hospitalizations)
9. Improving and Integrating Information Systems
(↑ Information)

Figure 2

Title V Block Grant Performance Measurement System



3.3 Annual Budget and Budget Justification

3.3.1 Completion of the Budget Forms

The annual Title V budget is summarized in Forms 2, 3, 4, and 5.

3.3.2 Other Requirements

New Jersey has maintained and increased commitment of state funding support for maternal and child health activities. Since 1989, maintenance of effort has included state appropriations for children with special health care needs and support for population based outreach and education for pregnant women and their infants to name a few.

State appropriations support a number of maternal and child health programs including but not limited to the following:

- ◆ Cleft lip and palate projects
- ◆ Sickle cell education and outreach
- ◆ Genetic services
- ◆ Family planning services
- ◆ Birth defects registry
- ◆ Infant mortality reduction including a new project focused on reduction of black infant mortality
- ◆ Sudden Infant Death Syndrome
- ◆ Childhood lead poisoning prevention
- ◆ Hemophilia services
- ◆ Catastrophic illness in children relief fund
- ◆ Handicapped children's fund which is used to support subspecialty care and case management services
- ◆ Fetal Alcohol Syndrome

Federal support included in our federal state partnership for maternal and child health is as follows:

From the Centers for Disease Control and Prevention:

- ◆ Childhood Lead Poisoning Prevention
- ◆ MCH Epi 66
- ◆ Preventive Health and Health Services Block Grant
- ◆ Birth Defects Centers of Excellence
- ◆ Asthma

From the Maternal and Child Health

- ◆ State System Development Initiative
- ◆ Abstinence Education
- ◆ Healthy Start

From Other Federal Sources

- ◆ Ryan White Pediatric AIDS
- ◆ Family Planning
- ◆ Perinatal Addictions
- ◆ Primary Care Cooperative Agreement

All of the funding sources are considered in the programmatic narrative portion of this application. There have been few variations in the allocation and expenditure of the federal/state partnership funds for maternal and child health over the last few years. State appropriations have included cost of living increases that are passed on to the service providers. New Jersey has undertaken several new or expanded initiatives over the past few years, which may in some cases, resulted in slight variations in allocations or expenditures.

The annual Title V budget is summarized in Forms 2, 3, 4, and 5.

3.4 Performance Measures

3.4.1 National “Core” Five Year Performance Measures

Table 1 lists the National “Core” Five Year Performance Measures

3.4.1.1 Five Year Performance Targets

Form 11 lists the National “Core” Five Year Performance Measures arranged in order by levels of the service pyramid with completed five year targets for each objective.

3.4.2 State “Negotiated” Five Year Performance Measures

3.4.2.1 Development of State Performance Measures

State “Negotiated” Five Year Performance Measures are listed in Table 1 and defined in detail on Form 16.

TABLE 1 - PERFORMANCE MEASURES SUMMARY SHEET

Core Performance Measures	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
1) The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.	X				X		
2) The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.	X				X		
3) The percent of Children with Special Health Care Needs (CSHCN) in the State who have a "medical/health home."		X			X		
4) Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (e.g., the sickle cell diseases) (combined).			X				X
5) Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.			X				X
6) The birth rate (per 1,000) for teenagers aged 15 - 17 years.			X				X
7) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.			X				X

TABLE 1 - PERFORMANCE MEASURES SUMMARY SHEET

8) The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.			X				X
9) Percentage of mothers whom breastfeed their infants at hospital discharge.			X				X
10) Percentage of newborns who have been screened for hearing impairment before hospital discharge.			X				X
11) Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN Program with a source of insurance for primary and specialty care.				X	X		
12) Percent of children without health insurance.				X	X		
13) Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.				X		X	
14) The degree to which the State assures family participation in program and policy activities in the State CSHCN Program.				X		X	
15) Percent of very low birth weight live births.				X			X
16) The rate (per 100,000) of suicide deaths among youths 15-19.				X			X
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.				X			X
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.				X			X

Negotiated State Performance Measures	Pyramid Level of Service Type of Service						
	DHC	ES	PBS	IB	C	P	RF
1) Percent of Black Preterm Births in NJ.				X			X
2) Proportion of newborns with confirmed positive newborn-screening tests that are receiving appropriate treatment.	X						X
3) Implementation of community based fetal and Infant Mortality Review Teams.				X	X		
4) Percent of children with elevated blood lead levels			X				X
5) Percent of repeat pregnancies among adolescent's 15-19 years of age.		X					X
6) Develop a State plan to decrease hospitalization for ambulatory sensitive conditions, especially asthma in children and adolescents.			X			X	
7) Percent of children with birth defects who are appropriately reported to the NJ Birth Defects Registry.				X			X
8) Improve information regarding potential risk factors associated with birth defects.				X			X
9) The percent of HIV exposed newborns receiving treatment.				X			X
10) Increase community partnerships for healthy adolescents.				X	X		

NOTE: DHC = Direct Health Care ES = Enabling Services PBS = Population Based Services

IB = Infrastructure Building C = Capacity P = Process RF = Risk Factor

3.4.2.2 Discussion of State Performance Measures

Maternal, Child and Community Health chose the percent of black preterm births in New Jersey as State Performance Measure #1. Previous sections concerning the Blue Ribbon Panel on Black Infant Mortality Reduction, the Black Infant Mortality Reduction Advisory Council, the BIBS campaign and MCH activities demonstrate the department's commitment to reduce black infant mortality. Infants who are born preterm are at the highest risk for infant mortality and morbidity. The percentage of black preterm births was selected to begin to address the underlying causes of black infant mortality and the racial disparity between preterm birth rates.

The proportion of newborns with a confirmed positive newborn screening test who are receiving appropriate treatment (State Performance Measure #2) was chosen to track the secondary prevention services of the newborn screening program. The program bridges the service gap to assure that life-saving clinical services are provided. This State Performance Measure is directly related to Core Performance Measure #4 and the Outcome Measures of Infant and Child Mortality (#2 and #5).

State Performance Measure #3 was selected to monitor progress toward the implementation of community-based Fetal and Infant Mortality Review Teams. This infrastructure building service will impact on Core Performance Measures #16, #17, #18 and all of the perinatal outcome measures. Increasing the understanding of the circumstances and factors associated with fetal and infant deaths will advance the State's ability to assess needs, improve the social and health care delivery system, and target resources and policies toward specific locations.

The percent of children with elevated blood lead levels (State Performance Measure # 4) was chosen because children in New Jersey have a higher than average exposure to lead in their environment. Children with elevated blood lead levels are at increased risk for behavioral, physiological and learning problems. Increased childhood morbidity will result from undetected and untreated lead poisoning.

The percent of repeat births among adolescents 15-19 years of age (State Performance Measure # 5) was chosen because teen parents are more likely to have another child within two years, often leading to increased hardship and economic dependency. This state performance measure will also impact on Core Performance Measure # 6.

State Performance Measure # 6 focuses on the development of a strategic plan to address hospitalizations for ambulatory sensitive conditions, especially asthma in children and adolescents. Efforts must be focused on identifying children and providing the children and their families the education and support services they need to reduce the affects of asthma. Assessing the number of children who are hospitalized for asthma and determining if they are linked appropriately with primary care is essential. Educating the children affected by asthma and their families on regarding the environmental triggers is also essential to help children reduce the number and severity of asthma attacks.

State Performance Measure #7, the percentage of children with birth defects who are appropriately reported to the NJ Birth Defects Registry, was chosen to improve the quality of the Birth Defect Registry. The Birth Defects Registry has been an invaluable tool for birth defects surveillance, needs assessment, service planning and research. Keeping the information as up-to-date and accurate as possible is critical for a population-based registry. Annual audits performed by the SCAEIS staff are necessary to identify children with birth defects that would otherwise not be entered into the Registry. The audits performed at every maternity hospital and facility with pediatric beds also provide an opportunity to provide reporting performance back to the individual facilities. While birth defects affect 3-4% of all newborns and are a leading cause of infant mortality, the cause of 40-60% of birth defects is unknown. Improving the infrastructure and quality of surveillance data is a prerequisite for developing better programs and advancing research toward prevention.

State Performance Measure #8, improving information regarding potential risk factors associated with birth defects, is another example of SCAEIS building the capacity and infrastructure necessary to perform surveillance and research related to birth defects. New Jersey

had the opportunity to apply for and was chosen as one of eight national Centers for Birth Defects Research and Prevention to collaborate with the CDC. New Jersey will be completing 300 case and 100 control interviews per year to identify potential risk factors for select birth defects. This opportunity will assist SCAEIS in building internal research capacity and developing future research opportunities.

State Performance Measure #9, the percent of perinatally exposed infants enrolled in treatment, was selected to focus efforts on reducing the perinatal transmission of HIV. Studies have demonstrated the dramatic reduction of perinatal transmission of HIV through the use of AZT. Accurately monitoring the identification and early management of pregnant women and at-risk infants should have a significant impact on reducing the perinatal transmission of HIV.

State Performance Measure #10 in which local communities will collaborate on the development and implementation of risk reduction activities targeting adolescents is considered critical. Strategies designed to reduce mortality and morbidity in the adolescent population cannot be conducted in isolation. To reduce risk taking behaviors among the adolescent population all youth serving organizations including health care providers must take responsibility to coordinate their efforts to be successful. Adolescents at risk for unintended pregnancies are also at risk for HIV and STD infection, just as those who are at risk for intentional and unintentional injury are at risk for encounters with the juvenile justice system and poor academic achievement.

3.4.2.3 Five Year Performance Targets

Form 12 contains the completed five year targets for each objective.

3.4.2.4 Review of State Performance Measures

To be completed by central and regional MCHB staff and state

3.4.3 Outcome Measures

Form 12 tracks outcome measures and projects five year targets for each outcome measure.

IV. REQUIREMENTS FOR THE ANNUAL PLAN [Section 505 (a)(2)(A)]

4.1 Program Activities Related to Performance Measures

Direct

Maternal, Child and Community Health will continue to support Fetal Alcohol Syndrome prevention projects and perinatal addiction treatment services. In addition, HealthStart prenatal providers will continue to provide comprehensive health services and maternity and newborn services in order to address very low birth weight live births (Core Performance Measure #16), very low birth weight infants delivered at high-risk facilities (Core Performance Measure #17), and first trimester prenatal care (Core Performance Measure #18).

In the area of child and adolescent health, movement has continued away from the provision of direct services. However, over \$570,000 in grant support will continue for family planning services targeted to the adolescent population, allowing confidential access to reproductive health clinical and counseling services to an anticipated 26,000 + teens. Through direct provision of family planning services efforts will continue toward teen pregnancy prevention (Core Performance Measure # 6) and reducing the number of teens experiencing repeat births (State Performance Measure # 5).

Activities to assure that State SSI beneficiaries less than 16 years old receiving rehabilitation services from the State Children with Special Health Care Needs (CSHCN) Program (Core Performance Measure #1) will continue with the agreement between Disability Determination and SCAEIS and the County Case Management Units. SCAEIS will accurately monitor the number of SSI eligibles per county and the number of SSI eligibles provided case management services including rehabilitative services. Training sessions for case managers on SSI eligibility and available services will continue on a quarterly basis.

SCAEIS will continue to assure that specialty and subspecialty services are geographically and financially accessible to CSHCN through its network of specialty centers (Core Performance Measure #2). The County Case Management Units will continue to receive training in order to direct families to insurance and financial sources in order to access specialty and subspecialty services.

Enabling Services

Grants will continue to support the home visiting and case management services and family education to improve parenting skills and knowledge regarding a child's development, health and safety and to link families with appropriate community based care. During FFY 2001 we anticipate serving over 1,600 families through the projects. The grants are provided to local health departments or community based agencies in 11 high-risk areas of the State. Children with lead poisoning are included in the program along with children at high-risk of preventable health or developmental problems. A major activity to be undertaken during the coming year for these projects is development and implementation of a uniform reporting system and methodology. This activity will help us assess our progress in meeting the Core and State Performance Measures related to immunization status, lead screening, and access to primary care. (Core Performance Measure #5 and #12 and #13 and State Performance Measure #4)

The success of the three adolescent parenting projects, which will also be continued for the next year, is also dependent on good evaluation data. During the coming year, efforts will focus on coordinating the evaluation of projects that are supported by not only the Department of Health and Senior Services but also those adolescent parenting projects that are supported with Department of Human Services funding. Over 250 pregnant or parenting adolescents and their infants will receive project services in the upcoming year.

The department's involvement with NJ KidCare will expand. Programs and services supported by the child and adolescent program will be involved in the outreach and recruitment of children and their families who may benefit from the program. All grantees of the program will receive training regarding enrollment procedures to assist families. This will serve to help

New Jersey decrease the percentage of uninsured children (Core Performance Measure #12). Our department's efforts will also be focused on quality assurance and assisting Medicaid with evaluating services provided by HMO's.

SCAEIS will continue to monitor the insurance status of CSHCN and to promote the concept of medical homes through County Case Management and Child and Adult Special Services centers (Performance Measure #3). The implementation of a standardized survey tool to assess the existence of a medical home would be extremely important for states to monitor this performance measure.

Population-Based Services

As described earlier in this document, the department is in the process of implementing recommendations from the report of the Blue Ribbon Panel on Black Infant Mortality Reduction with input from the Advisory Council on Black Infant Mortality Reduction. The specific activities to be implemented are as follows:

- ◆ A \$1 Million public awareness campaign for a two year period, including print ads, television ads, radio, and community relations; was launched May 1999.
- ◆ A 1-800 number, (1-888-414-BIBS), linked with our Family Health line, to specifically address inquiries regarding black infant mortality; was established,
- ◆ A resource center to act as a statewide clearing house on information concerning black infant mortality and to provide technical assistance to the professional community; was established in the Northern New Jersey MCHC and,
- ◆ A provider communication campaign that will support continuing education activities and heighten awareness of the issue of black infant mortality among physicians, nurses, and other health and social service professionals was launched in September 1999.

There are several exciting initiatives, which will be taking place during the next funding period relative to population-based, and prevention oriented services for children and

adolescents. Meeting our State Performance Measure #4 for lead poisoning will be a priority. The following will facilitate compliance with the new lead screening law:

- ◆ Collaboration with Medicaid, Physician Lead Advisory Committee and other professional organizations to promote screening;
- ◆ Maintenance and enhancement of the statewide surveillance system;
- ◆ Ensuring the coordination of environmental activities, case management follow up and community education; and
- ◆ Carrying out community based education and primary prevention through the Newark Partnership for Lead Safe Children.

In the area of oral health the following activities will be completed to meet Core Performance Measure #7:

- The regional dental programs will continue extensive outreach and education to preschool and school age children and their families, teachers, care takers and other health professionals including WIC and local health providers;
- The school fluoride mouth rinse project will target schools at highest risk and who may benefit most from the project. MCH support will be phased out for schools that have participated in the past, but based on evaluation are not considered “at risk”; and
- Efforts will be made to encourage schools not directly supported to continue the fluoride mouth rinse projects using other funding sources.

The NJ SIDS Center will provide bereavement counseling and follow up services for the families of infants who die of SIDS. SIDS educational and prevention programs will be conducted for the general public, health care providers, emergency responders and law enforcement personnel. Preventive education will focus on the state’s urban centers to educate new parents and caregivers about prevention strategies. Information regarding prenatal smoking and smoking around an infant and the Back to Sleep campaign will be emphasized as key prevention strategies.

Injury prevention activities will be enhanced during the upcoming year to meet Core Performance Measures #8 and #16 (motor vehicle and suicide). The Child and Adolescent Health Program will facilitate increased local health involvement in promoting safety in community childcare agencies. The Program will also continue to participate and support an annual Health in Childcare Conference for health and childcare professionals.

Teen pregnancy prevention efforts will be the charge of the Adolescent Pregnancy Advisory Council (CPM #6). Staff will also continue to be active in the National Campaign to Prevent Teen Pregnancy. In collaboration with the Department of Human Services the staff will continue to participate and coordinate teen pregnancy prevention services through the following activities: cross training of family planning and school based youth services staff; and coordination of local programs.

Over 10,000 adolescents, under the age of 21, through the Partnerships for Healthy Adolescents in 10 communities and the Family Planning Enhanced Adolescent Service, will be educated about risk taking-behavior including the adverse impact of driving under the influence of drugs and/or alcohol and be counseled or referred for depression or other mental health problems.

Breast feeding promotion activities will continue statewide with MCH Consortia and local WIC agencies receiving funding through WIC. The MCH Consortia within regions coordinate Professional outreach and education. Strategic planning by the Breastfeeding workgroup described in section 4.2 has identified increasing exclusive breastfeeding initiation rates as a major priority, especially for minority mothers. Additional data on duration of breastfeeding may be obtained this year through implementation of PRAMS.

Activities directed toward increasing the percentage of newborns who have been screened for hearing impairment before hospital discharge (Performance Measure #10) shall continue with reporting from the Electronic Birth Certificate. Improvements in reporting screenings and risk factors as well as the sharing of hospital level reports should provide the objective data to further increase screening rates. With several hospitals initiating universal

screening this performance measure may rapidly rise for selected facilities. The amended regulation requesting universal electrophysiologic screening of infants prior to hospital discharge and one month of age will take effect 2002.

Infrastructure Services

Activities to improve newborn screening rates (Core Performance Measure #4) include the applied research activities under the MCH EPI 661 grant to match Electronic Birth Certificate records to Inborn Errors of Metabolism records. Future efforts will be directed toward integrating the two datasets at the hospital level to track screening before discharge, improving the quality of data in the databases, identifying patterns in the unscreened newborns, and improving the timeliness of the follow-up of positive screens (State Performance Measure #2).

Building upon technical assistance training supported in FFY 1998 by MCH Region II, Child Health and MCH Consortia staff will provide the child and adolescent home visiting projects training in Nursing Child Assessment Satellite Training (NCAST). Additionally, the Child Health Regional Network will continue to offer training opportunities to local public health nurses on child and adolescent issues.

Violence continues to be a major contributor to child and adolescent mortality. In addition to supporting early childhood programs (POrSCHe) and the Adolescent Partnerships to reduce child abuse and neglect and injury among adolescents respectively, the Child and Adolescent Health Program will be working to reduce violence among youth. The program is collaborating with the Emergency Medical Services for Children program and a subcommittee of their Council on protocols for emergency departments and first responders to address youth-to-youth violence. Staff continue to facilitate the reception at four sites in New Jersey of a series of teleconferences on youth violence sponsored by the Harvard School of Public Health.

To meet State Performance Measure # 6, staff will focus on the development of a strategic plan to reduce the number of hospitalizations for ambulatory sensitive conditions,

especially asthma in children and adolescents. This planning will be a collaboration among the Child and Adolescent Health Program, Special Child and Adult Health and Early Intervention Services, the Division of Epidemiology, Environmental and Occupational Health, and the Office of Minority Health. Staff will also continue to work closely with statewide and regional asthma coalitions to enhance the quality and availability of services for children with asthma.

Annual audits of facilities reporting to the Birth Defects registry will continue to improve the appropriate reporting of children with birth defects (State Performance Measure # 7). Expanded information collection during the audits and improved analysis of unreported children would further improve reporting to the Birth Defects Registry. Collaborating as one of eight National Centers for Birth Defects Research and Prevention with the CDC, SCAEIS will also further enhance its capacity and infrastructure necessary to perform surveillance and research related to birth defects (State Performance Measure # 8).

Improved outreach and early identification and maintenance in care of HIV positive pregnant women will continue to reduce the perinatal transmission of HIV by increasing the percentage of newborns enrolled in treatment (State Performance Measure #9). Accurately monitoring the identification and early management of at-risk newborns will highlight specific areas that need improvement. Increasing the percent of perinatally exposed newborns treated with appropriate prenatal, perinatal, and neonatal antiviral therapy should continue to significantly reduce the perinatal transmission of HIV.

Activities to increase the percent of CSHCN in the State CSHCN program with a source of insurance for primary and specialty care (Performance Measure #11) will continue with monitoring of the insurance status of children served by SCAEIS. Specific improvements in data collection will be made to decrease the percent of unknown insurance status. Providing referrals and enabling services to access primary and specialty care will continue with case management services at no expense to families.

SCAEIS will continue to collaborate with parents of children with special health care needs (CSHCN) to increase family participation in the activities of CSHCN programs

(Performance Measure #14). Collaboration with the Statewide Parents Advocacy Network will further develop the Parent-to-Parent Network and a Family Voices parent group in New Jersey. In preparation of the expansion of managed care and its impact of CSHCN, SCAEIS will continue to work with Medicaid, County Case Management Units and parents to assure access to services. For the Pediatric HIV Family Centered Care Network, expansion of the existing consumer representation in the Network planning process and appointment of a Consumer Advisory Board (CAB) has been the focus in 1999-2000. Consumer representation on the Ryan White Title IV Executive Advisory Committee has increased from 1 representative to 2 or 3 at each meeting.

4.2 Other Program Activities

The Family Health Line (FHL) 1-800-328-3838 and the Black Infants Better Survival Line 1-888-414-2427 (BIBS) are components of a toll-free telephone information and referral service for New Jersey residents seeking referral to health care services. Access is available to the following MCH programs: Perinatal Health Services, Preconceptional Health/Folic Acid Counseling, Fetal Alcohol Syndrome Prevention, Perinatal Addiction Services, Family Planning, HealthStart, Specialized Pediatric Services and Black Infants Better Survival. Other programs such as Pediatric Case Management, Pediatric HIV Treatment, WIC, Newborn Hearing Screening, Immunization, Cancer Education and Early Detection Services, Nutritional Resources, Cystic Fibrosis and all other non-specific referrals are covered. Services are available 24 hours a day, seven days a week. Telephone counselors in charge of the system receive regular training to assure that consumers receive current information they need to access appropriate services. The AT&T Language line is accessed for any needed translation.

There has been a long-standing relationship with the State's Medicaid program. An interagency agreement concerning EPSDT and related pediatric services has been in effect now for seven years. This agreement, which was under review to reflect changing roles due to Medicaid managed care, is again being renegotiated to reflect the changes in roles due to implementation of New Jersey KidCare. Programs are meeting on a periodic basis and will be drafting a new agreement prior to the end of this federal fiscal year.

4.3 Public Input

A public hearing was held on May 30, 2000 in Trenton to review a draft of the Maternal and Child Health Block Grant Application. A draft of the application was posted on the Departments website (www.state.nj.us/health/) four weeks prior to the public hearing. Notice of the public hearing was published in 6 local newspapers throughout the State. Notification of the public hearing and availability of the draft application on the Department's website was mailed to 300 individuals. Verbal testimony was given by 13 individuals. Written testimony was received from 2 individuals. The majority of the public comments concerned children with special health care needs. Issues addressed continuing support for comprehensive Child Evaluation Centers and the case management system, low reimbursement rates for Medicaid providers, and barriers to services under managed care.

4.4 Technical Assistance

The State's technical assistance needs are listed on Form 15.

V. SUPPORTING DOCUMENTS

5.1 Glossary – New Jersey Modified

GLOSSARY

Adequate prenatal care - Prenatal care were the observed to expected prenatal visits is greater than or equal to 80% (the Kotelchuck Index).

Administration of Title V Funds - The amount of funds the State uses for the management of the Title V allocation. It is limited by statute to 10 percent of the Federal Title V allotment.

Assessment - (see “Needs Assessment”)

Capacity - Program capacity includes delivery systems, workforce, policies, and support systems (e.g., training, research, technical assistance, and information systems) and other infrastructure needed to maintain service delivery and policy making activities. Program capacity results measure the strength of the human and material resources necessary to meet public health obligations. As program capacity sets the stage for other activities, program capacity results are closely related to the results for process, health outcome, and risk factors. Program capacity results should answer the question, “What does the State need to achieve the results we want?”

Capacity Objectives - Objectives that describe an improvement in the ability of the program to deliver services or affect the delivery of services.

Care Coordination Services for Children With Special Health Care Needs (CSHCN, see definition below) - those services that promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children with special health care needs and their families. [*Title V Sec. 501(b)(3)*]. Provided in New Jersey by the County Case Management Units.

Carryover (as used in Forms 2 and 3) - The unobligated balance from the previous years MCH Block Grant Federal Allocation.

Case Management Services - For pregnant women - those services that assure access to quality prenatal, delivery and postpartum care. For infants up to age one - those services that assure access to quality preventive and primary care services. (*Title V Sec. 501(b)(4)*)

Children -A child from 1st birthday through the 21st year, who is not otherwise included in any other class of individuals.

Children With Special Health Care Needs (CSHCN) - (*For budgetary purposes*) Infants or children from birth through the 21st year with special health care needs who the State has elected to provide with services funded through Title V. CSHCN are children who have health problems requiring more than routine and basic care including children with or at risk of disabilities,

chronic illnesses and conditions and health-related education and behavioral problems. (*For planning and systems development*) - Those children who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.

Children With Special Health Care Needs (CSHCN) - Constructs of a Service System

1. State Program Collaboration with Other State Agencies and Private Organizations. States establish and maintain ongoing interagency collaborative processes for the assessment of needs with respect to the development of community-based systems of services for CSHCN. State programs collaborate with other agencies and organizations in the formulation of coordinated policies, standards, data collection and analysis, financing of services, and program monitoring to assure comprehensive, coordinated services for CSHCN and their families.
2. State Support for Communities. State programs emphasize the development of community-based programs by establishing and maintaining a process for facilitating community systems building through mechanisms such as technical assistance and consultation, education and training, common data protocols, and financial resources for communities engaged in systems development to assure that the unique needs of CSHCN are met.
3. Coordination of Health Components of Community-Based Systems. A mechanism exists in communities across the State for coordination of health services with one another. This includes coordination among providers of primary care, habilitative and rehabilitative services, other specialty medical treatment services, mental health services, and home health care.
4. Coordination of Health Services with Other Services at the Community Level. A mechanism exists in communities across the State for coordination and service integration among programs serving CSHCN, including early intervention and special education, social services, and family support services.

Classes of Individuals - authorized persons to be served with Title V funds. See individual definitions under “Pregnant Women,” “Infants,” “Children with Special Health Care Needs,” “Children,” and “Others.”

Community - a group of individuals living as a smaller social unit within the confines of a larger one due to common geographic boundaries, cultural identity, a common work environment, common interests, etc.

Community-based Care - services provided within the context of a defined community.

Community-based Service System - an organized network of services that are grounded in a plan developed by a community and that is based upon needs assessments.

Coordination (see Care Coordination Services)

Culturally Sensitive - the recognition and understanding that different cultures may have different concepts and practices with regard to health care; the respect of those differences and the development of approaches to health care with those differences in mind.

Culturally Competent - the ability to provide services to clients that honor different cultural beliefs, interpersonal styles, attitudes and behaviors and the use of multicultural staff in the policy development, administration and provision of those services.

Deliveries - women who received a medical care procedure (were provided prenatal, delivery or postpartum care) associated with the delivery or expulsion of a live birth or fetal death.

Direct Health Care Services - those services generally delivered one-on-one between a health professional and a patient in an office, clinic or emergency room which may include primary care physicians, registered dietitians, public health or visiting nurses, nurses certified for obstetric and pediatric primary care, medical social workers, nutritionists, dentists, sub-specialty physicians who serve children with special health care needs, audiologists, occupational therapists, physical therapists, speech and language therapists, specialty registered dietitians. Basic services include what most consider ordinary medical care, inpatient and outpatient medical services, allied health services, drugs, laboratory testing, x-ray services, dental care, and pharmaceutical products and services. State Title V programs support - by directly operating programs or by funding local providers - services such as prenatal care, child health including immunizations and treatment or referrals, school health and family planning. For CSHCN, these services include specialty and subspecialty care for those with HIV/AIDS, hemophilia, birth defects, chronic illness, and other conditions requiring sophisticated technology, access to highly trained specialists, or an array of services not generally available in most communities.

Electronic Birth Certificate (EBC) – an expanded birth certificate which includes the prenatal, labor, delivery, and in-hospital postpartum history of all live births in New Jersey birthing facilities. Information for the EBC is collected by the birthing facilities and submitted electronically to the State.

Enabling Services - Services that allow or provide for access to and the derivation of benefits from, the array of basic health care services and include such things as transportation, translation services, outreach, respite care, health education, family support services, purchase of health insurance, case management, coordination of services with Medicaid, and WIC. These services are especially required for the low income, disadvantaged, geographically or culturally isolated, and those with special and complicated health needs. For many of these individuals, the enabling services are essential - for without them access is not possible. Enabling services most commonly provided by agencies for CSHCN include transportation, care coordination, translation services, home visiting, and family outreach. Family support activities include parent support groups, family training workshops, advocacy, nutrition and social work.

EPSDT - Early and Periodic Screening, Diagnosis and Treatment - a program for medical assistance recipients under the age of 21, including those who are parents. The program has a Medical Protocol and Periodicity Schedule for well-child screening that provides for regular

health check-ups, vision/hearing/dental screenings, immunizations and treatment for health problems.

Family-centered Care - a system or philosophy of care that incorporates the family as an integral component of the health care system.

Federal (Allocation) (as it applies specifically to the Application Face Sheet [SF 424] and Forms 2 and 3) -The monies provided to the States under the Federal Title V Block Grant in any given year.

Family Health Services (FHS). – the Division with the New Jersey Department of Health and Senior Services that includes all Maternal and Child Health (Title V) programs including programs for Children with Special Health Care Needs.

Government Performance and Results Act (GPRA) - Federal legislation enacted in 1993 that requires Federal agencies to develop strategic plans, prepare annual plans setting performance goals, and report annually on actual performance.

Health Care System - the entirety of the agencies, services, and providers involved or potentially involved in the health care of community members and the interactions among those agencies, services and providers.

Infants - Children under one year of age not included in any other class of individuals.

Infrastructure Building Services - The services that are the base of the MCH pyramid of health services and form its foundation are activities directed at improving and maintaining the health status of all women and children by providing support for development and maintenance of comprehensive health services systems including development and maintenance of health services standards/guidelines, training, data and planning systems. Examples include needs assessment, evaluation, planning, policy development, coordination, quality assurance, standards development, monitoring, training, applied research, information systems and systems of care. In the development of systems of care it should be assured that the systems are family centered, community based and culturally competent.

Jurisdictions - As used in the Maternal and Child Health block grant program: the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, the Republic of the Marshall Islands, the Federated States of Micronesia and the Republic of Palau.

Kotelchuck Index - An indicator of the adequacy of prenatal care. See *Adequate Prenatal Care*.

Local Funding (as used in Forms 2 and 3) - Those monies deriving from local jurisdictions within the State that are used for MCH program activities.

Low Income - an individual or family with an income determined to be below the income official

poverty line defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981.[Title V, Sec. 501 (b)(2)]

MCH Pyramid of Health Services - (see “Types of Services”)

Maternal, Child and Community Health Service (MCCH) – The Service Unit within the Division of Family Health that includes perinatal and MCH regional services programs. MCCH has three major programs: Perinatal Services, Reproductive Health, and Child and Adolescent Health.

Maternal and Child Health Consortia (MCHC) - a regionalized network of maternal and child health providers with emphasis on prevention and community-based activities. The consortia are charged with developing regional perinatal and pediatric plans, total quality improvement systems, professional and consumer education, transport systems, data analysis, and infant follow-up programs.

Measures - (see “Performance Measures”)

Needs Assessment - a study undertaken to determine the service requirements within a jurisdiction. For maternal and child health purposes, the study is aimed at determining: 1) What is essential in terms of the provision of health services; 2) What is available; and, 3) What is missing

NJ KidCare – the State Children’s Health Insurance Program for New Jersey designed to provide comprehensive and affordable health insurance to eligible uninsured children, which is administered by the Department of Human Services.

Objectives - The yardsticks by which an agency can measure its efforts to accomplish a goal. (See also “Performance Objectives”)

Other Federal Funds (Forms 2 and 3) - Federal funds other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program. These may include, but are not limited to: WIC, EMSC, Healthy Start, SPRANS, HIV/AIDs monies, CISS funds, MCH targeted funds from CDC and MCH Education funds.

Others (as in Forms 4, 7, and 10) - Women of childbearing age, over age 21, and any others defined by the State and not otherwise included in any of the other listed classes of individuals.

Outcome Objectives - Objectives that describe the eventual result sought, the target date, the target population, and the desired level of achievement for the result. Outcome objectives are related to health outcome and are usually expressed in terms of morbidity and mortality.

Outcome Measure - The ultimate focus and desired result of any set of public health program activities and interventions is an improved health outcome. Morbidity and mortality statistics are indicators of achievement of health outcome. Health outcomes results are usually longer term

and tied to the ultimate program goal. Outcome measures should answer the question, “Why does the State do our program?”

Performance Indicator - The statistical or quantitative value that expresses the result of a performance objective.

Performance Measure - a narrative statement that describes a specific maternal and child health need, or requirement, that, when successfully addressed, will lead to, or will assist in leading to, a specific health outcome within a community or jurisdiction and generally within a specified time frame. (Example: “The rate of women in [State] who receive early prenatal care in 19__.” This performance measure will assist in leading to [the health outcome measure of] reducing the rate of infant mortality in the State).

Performance Measurement - The collection of data on, recording of, or tabulation of results or achievements, usually for comparing with a benchmark.

Performance Objectives - A statement of intention with which actual achievement and results can be measured and compared. Performance objective statements clearly describe what is to be achieved, when it is to be achieved, the extent of the achievement, and target populations.

Population Based Services - Preventive interventions and personal health services, developed and available for the entire MCH population of the State rather than for individuals in a one-on-one situation. Disease prevention, health promotion, and statewide outreach are major components. Common among these services are newborn screening, lead screening, immunization, Sudden Infant Death Syndrome counseling, oral health, injury prevention, nutrition and outreach/public education. These services are generally available whether the mother or child receives care in the private or public system, in a rural clinic or an HMO, and whether insured or not.

PRAMS - Pregnancy Risk Assessment Monitoring System - a surveillance project of the Centers for Disease Control and Prevention (CDC) and State health departments to collect State- specific, population-based data on maternal attitudes and experiences prior to, during, and immediately following pregnancy.

Pregnant Woman - A female from the time that she conceives to 60 days after birth, delivery, or expulsion of fetus.

Preventive Services - activities aimed at reducing the incidence of health problems or disease prevalence in the community, or the personal risk factors for such diseases or conditions.

Primary Care - the provision of comprehensive personal health services that include health maintenance and preventive services, initial assessment of health problems, treatment of uncomplicated and diagnosed chronic health problems, and the overall management of an individual's or family's health care services.

Process - Process results are indicators of activities, methods, and interventions that support the achievement of outcomes (e.g., improved health status or reduction in risk factors). A focus on process results can lead to an understanding of how practices and procedures can be improved to reach successful outcomes. Process results are a mechanism for review and accountability, and as such, tend to be shorter term than results focused on health outcomes or risk factors. The utility of process results often depends on the strength of the relationship between the process and the outcome. Process results should answer the question, “Why should this process be undertaken and measured (i.e., what is its relationship to achievement of a health outcome or risk factor result)?”

Process Objectives - The objectives for activities and interventions that drive the achievement of higher-level objectives.

Program Income (as used in the Application Face Sheet [SF 424] and Forms 2 and 3) - Funds collected by State MCH agencies from sources generated by the State’s MCH program to include insurance payments, MEDICAID reimbursements, HMO payments, etc.

Risk Factor Objectives - Objectives that describe an improvement in risk factors (usually behavioral or physiological) that cause morbidity and mortality.

Risk Factors - Public health activities and programs that focus on reduction of scientifically established direct causes of, and contributors to, morbidity and mortality (i.e., risk factors) are essential steps toward achieving health outcomes. Changes in behavior or physiological conditions are the indicators of achievement of risk factor results. Results focused on risk factors tend to be intermediate term. Risk factor results should answer the question, “Why should the State address this risk factor (i.e., what health outcome will this result support)?”

Special Child, Adult, and Early Intervention Services (SCAEIS) – The Service Unit within the Division of Family Health Services that includes all programs for Children with Special Health Care Needs. SCAEIS consists of the following programs and services: Early Identification and Monitoring, Family Centered Care Services, Child and Adult Special Services, and Early Intervention Services.

State - as used in this guidance, includes the 50 States and the 9 jurisdictions. (See also, Jurisdictions)

State Funds (as used in Forms 2 and 3) - The State’s required matching funds (including overmatch) in any given year.

Systems Development - activities involving the creation or enhancement of organizational infrastructures at the community level for the delivery of health services and other needed ancillary services to individuals in the community by improving the service capacity of health care service providers.

Technical Assistance (TA) - the process of providing recipients with expert assistance of specific

health related or administrative services that include; systems review planning, policy options analysis, coordination coalition building/training, data system development, needs assessment, performance indicators, health care reform wrap around services, CSHCN program development/evaluation, public health managed care quality standards development, public and private interagency integration and, identification of core public health issues.

Title XIX, number of infants entitled to - The unduplicated count of infants who were eligible for the State's Title XIX (MEDICAID) program at any time during the reporting period.

Title XIX, number of pregnant women entitled to - The number of pregnant women who delivered during the reporting period who were eligible for the State's Title XIX (MEDICAID) program

Title V, number of deliveries to pregnant women served under - Unduplicated number of deliveries to pregnant women who were provided prenatal, delivery, or post-partum services through the Title V program during the reporting period.

Title V, number of infants enrolled under - The unduplicated count of infants provided a direct service by the State's Title V program during the reporting period.

Total MCH Funding - All the MCH funds administered by a State MCH program which is made up of the sum of the *Federal* Title V Block grant allocation, the *Applicant's* funds (carryover from the previous year's MCH Block Grant allocation - the unobligated balance), the *State* funds (the total matching funds for the Title V allocation - match and overmatch), *Local* funds (total of MCH dedicated funds from local jurisdictions within the state), *Other* federal funds (monies other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program), and *Program Income* (those collected by state MCH agencies from insurance payments, MEDICAID, HMO's, etc.).

Types of Services - The major kinds or levels of health care services covered under Title V activities. See individual definitions under "Infrastructure Building", "Population Based Services", "Enabling Services" and "Direct Medical Services".

YRBS - Youth Risk Behavior Survey - A national school-based survey conducted annually by CDC and State health departments to assess the prevalence of health risk behaviors among high school students.

5.2 Assurances and Certifications

ASSURANCES -- NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have any questions, please contact the Awarding Agency. Further, certain federal assistance awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the assistance; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.
3. Will establish safeguards to prohibit employees from using their position for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. Sects. 4728-2763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to non-discrimination. These include but are not limited to (a) Title VI of the Civil Rights Act of 1964 (P.L. 88 Sect. 352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. Sects. 1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. Sect. 794), which prohibits discrimination on the basis of handicaps; (d) The Age Discrimination Act of 1975, as amended (42 U.S.C. Sects 6101 6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office of Treatment Act of 1972 (P.L. 92-255), as amended, relating to non-discrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to non-discrimination on the basis of alcohol abuse or alcoholism; (g) Sects. 523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. Sect.

3601 et seq.), as amended, relating to non-discrimination in the sale, rental, or financing of housing; (i) any other non-discrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other non-discrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. Sects 1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. Sects. 276a to 276a-7), the Copeland Act (40 U.S.C. Sect 276c and 18 U.S.C. Sect. 874), the Contract Work Hours and Safety Standards Act (40 U.S.C. Sects. 327-333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in flood plains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. Sects. 1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. 7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. Sects 1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers systems

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. Sect. 470), EO 11593 (identification

and preservation of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. Sects. 469a-1 et seq.)

14. Will comply with P.L.93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. 2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by the award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. Sects. 4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply will all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

By signing and submitting this proposal, the applicant, defined as the primary participant in accordance with 45 CFR Part 76, certifies to the best of its knowledge and belief that it and its principals:

- (a) are not presently debarred, suspended proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- (b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission or fraud or criminal judgment in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- (c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission or any of the offenses enumerated in paragraph (b) of the certification; and
- (d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause, titled “Certification Regarding Debarment, Suspension, In-eligibility, and Voluntary Exclusion -- Lower Tier Covered Transactions” in all lower tier covered transactions (i.e. transactions with sub-grantees and/or contractors) in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

- (a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee’s workplace and specifying the actions that will be taken against employees for violation of such prohibition;
- (b) Establishing an ongoing drug-free awareness program to inform employees about-
 - (1) The dangers of drug abuse in the workplace;
 - (2) The grantee’s policy of maintaining a drug-free workplace,
 - (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
 - (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- (c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- (d) Notifying the employee in the statement required by paragraph (a) above, that, as a condition of employment under the grant, the employee will-
 - (1) Abide by the terms of the statement; and
 - (2) Notify the employer in writing of his or her conviction for violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- (e) Notify the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- (f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d)(2), with respect to any employee who is so convicted-
 - (1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended, or
 - (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- (g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the

DHHS has designated the following central point for receipt of such notices:

Division of Grants Policy and Oversight
Office of Management and Acquisition
Department of Health and Human Services
Room 517-D
200 Independence Avenue, S.W.
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled “Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,” generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. The requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief that:

- (1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
- (2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, “Disclosure of Lobbying Activities,” in accordance with its instructions. (If needed, Standard Form-LLL, “Disclosure of Lobbying Activities,” its instructions, and continuation sheet are included at the end of this application form.)
- (3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for

making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18 if the services are funded by Federal programs either directly or through State or local governments by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable Federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing this certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Service strongly encourages all grant recipients to provide a smoke free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of American people.

5.3 Other Supporting Documents

Appendix 1 – Resumes

Appendix 2 – Organizational Charts

Appendix 3 – Public Hearing Announcement

Appendix 4 – Ten Year MCH Trend Charts

- Chart 1 1st Trimester Prenatal Care Initiation
- Chart 2 Adequacy of Prenatal Care (Kotelchuck APNC Index)
- Chart 3 No Prenatal Care
- Chart 4 Low Birthweight
- Chart 5 Low Birthweight and Very Low Birthweight
- Chart 5A Appropriate Level of Delivery According to Perinatal Guidelines
- Chart 6 Teen Fertility Rates 15-17 Years of Age
- Chart 7 Neonatal and Postneonatal Mortality
- Chart 8 Early Neonatal and Late Neonatal Mortality
- Chart 9 Infant Mortality by Race/Ethnicity
- Chart 10 Birthweight Specific Infant Mortality by Race/Ethnicity
- Chart 11 Periods of Risk Approach to Fetal and Infant Mortality
- Chart 12 Infant Cause of Death
- Chart 13 Lead Screening
- Chart 14 Births to Teens (10-19 Years)

5.4 Core Health Status Indicator Forms – See Forms

5.5 Core Health Status Indicator Detail Sheets – See Forms

5.6 Developmental Health Status Indicator Forms – See Forms

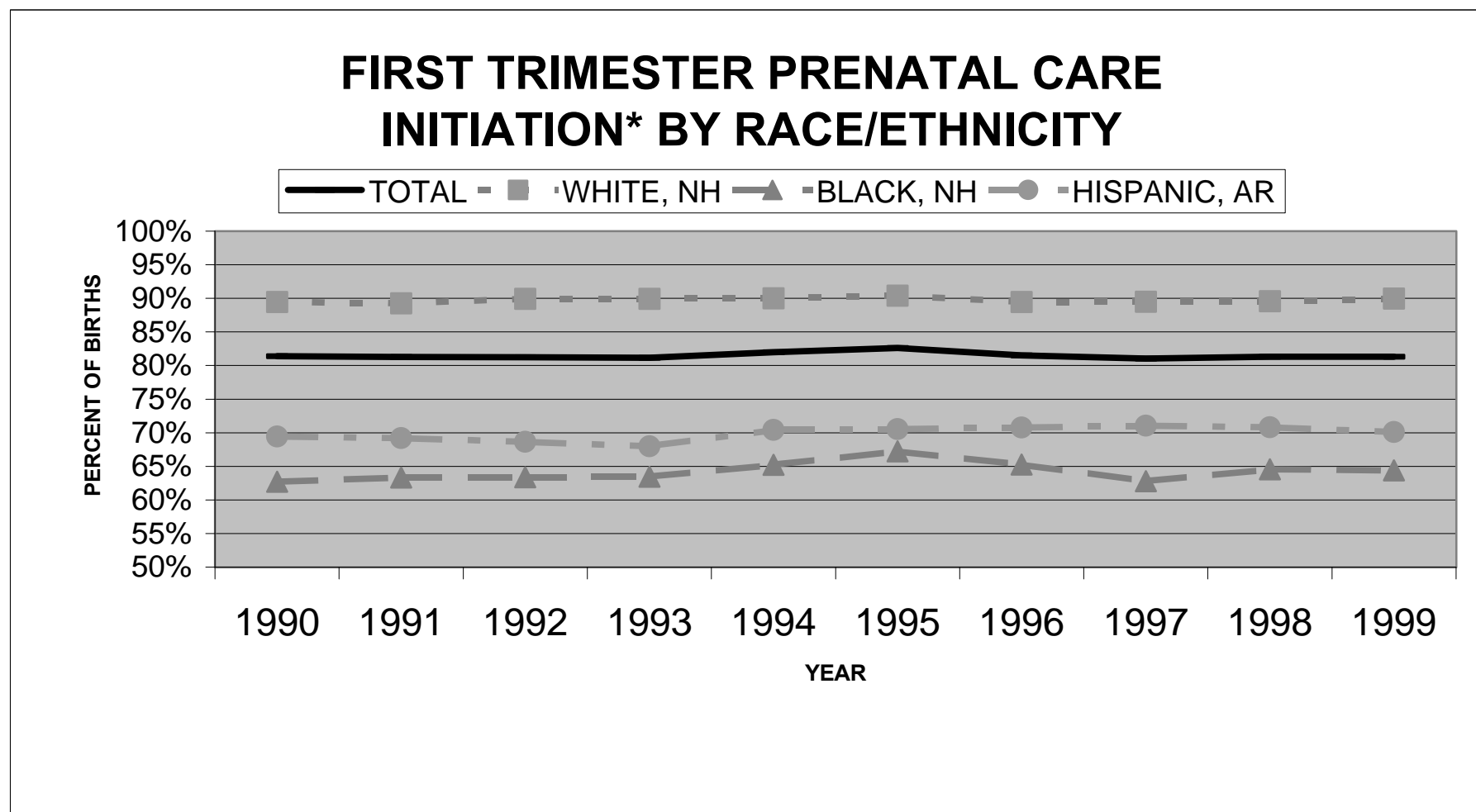
5.7 Developmental Health Status Indicator Detail Sheets – See Forms

5.8 All Other Forms – See Forms

5.9 National “Core” Performance Measure Detail Sheets – See Forms

5.10 State "Negotiated" Performance Measure Detail Sheets – See Forms

5.11 Outcome Measure Detail Sheets – See Forms



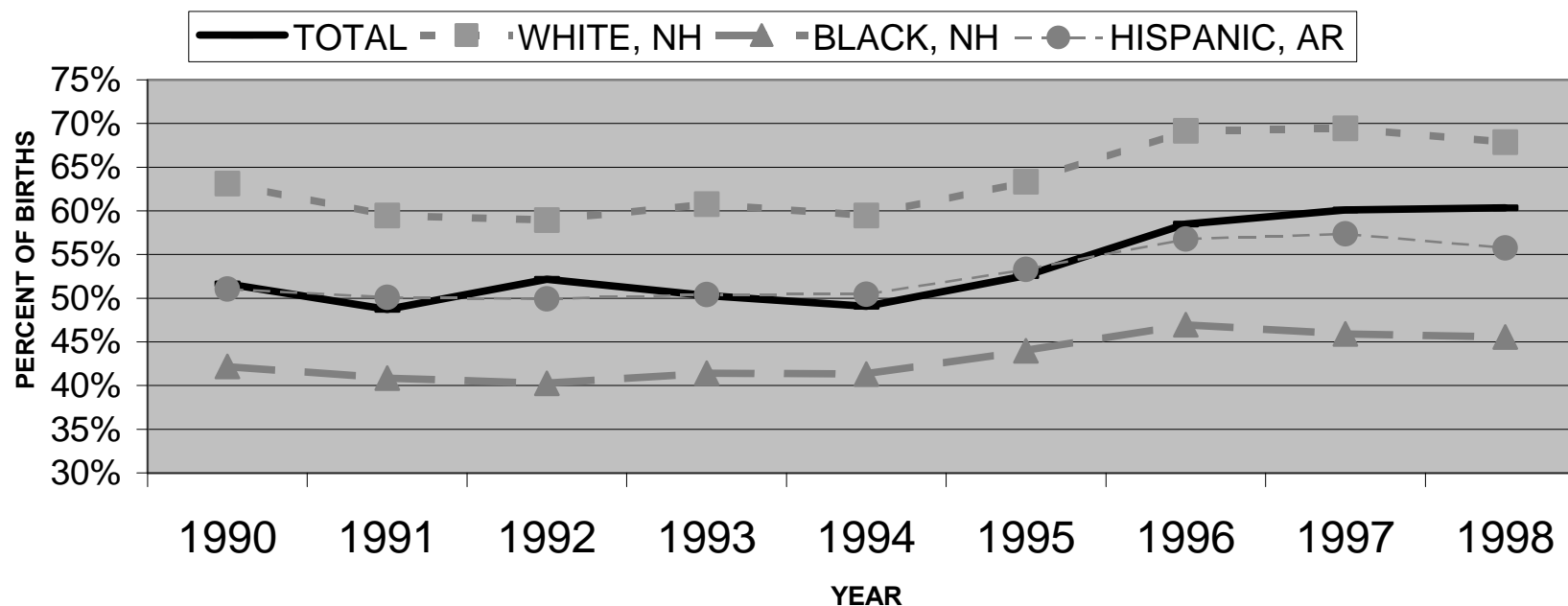
Source: NJDHSS Birth Certificate Files, as of 3/2000, New Jersey Residents

*Initiation of prenatal care self-report as within first 13 weeks on EBC. Missing and unknown responses excluded from calculations

Race/ethnic groups - Hispanic regardless of race; white, Non-Hispanic; black, Non-Hispanic

1997, 1998 & 1999 data is provisional

ADEQUACY OF PRENATAL CARE* (KOTELCHUCK APNCI) BY RACE/ETHNICITY

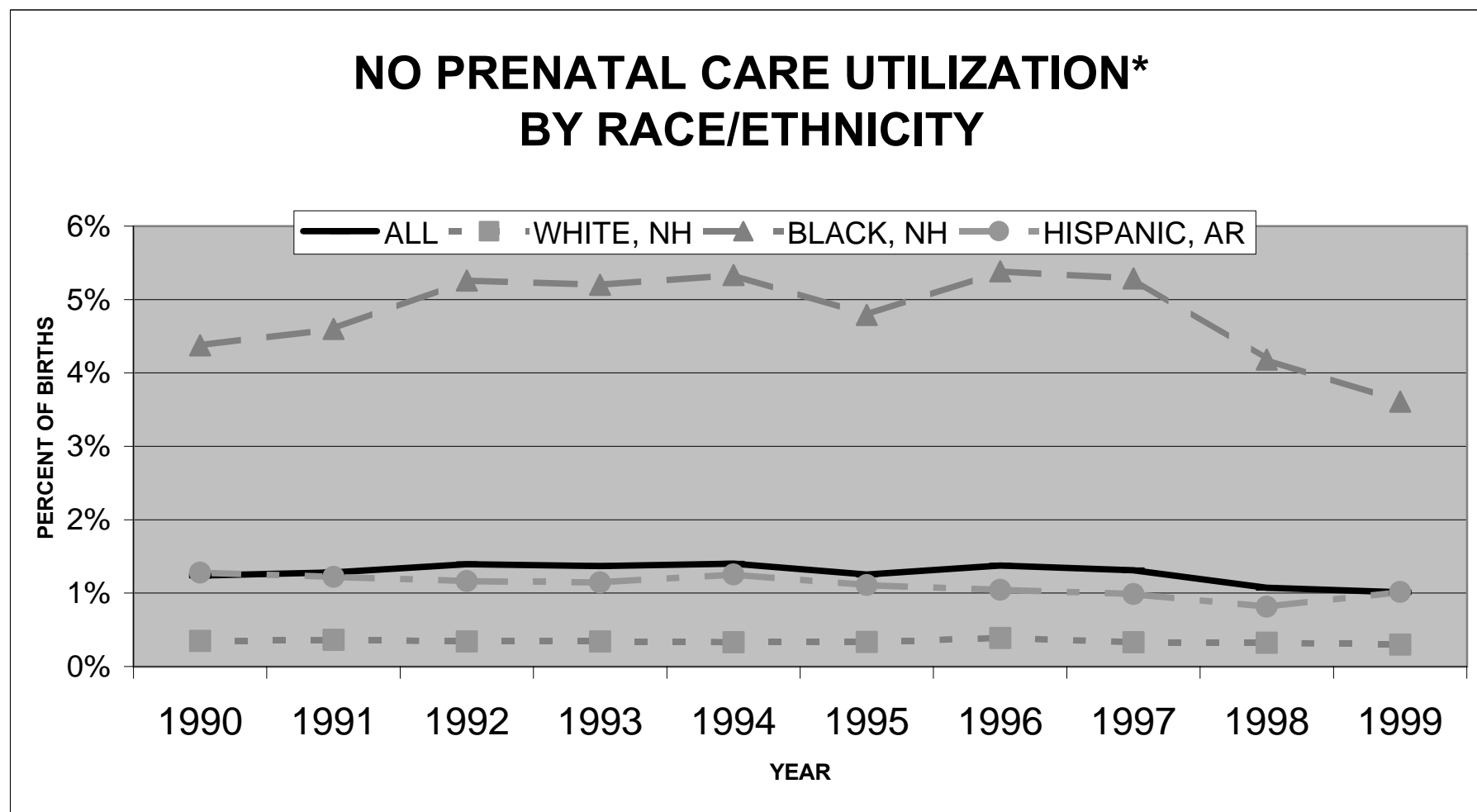


Source: NJDHSS Birth Certificate Files, as of 3/2000, New Jersey Residents

*Adequacy of prenatal care as defined by Kotelchuck APNC Index. Missing and unknown responses excluded from calculations

Race/ethnic groups - Hispanic regardless of race; white, Non-Hispanic; black, Non-Hispanic

1997, 1998 & 1999 data is provisional

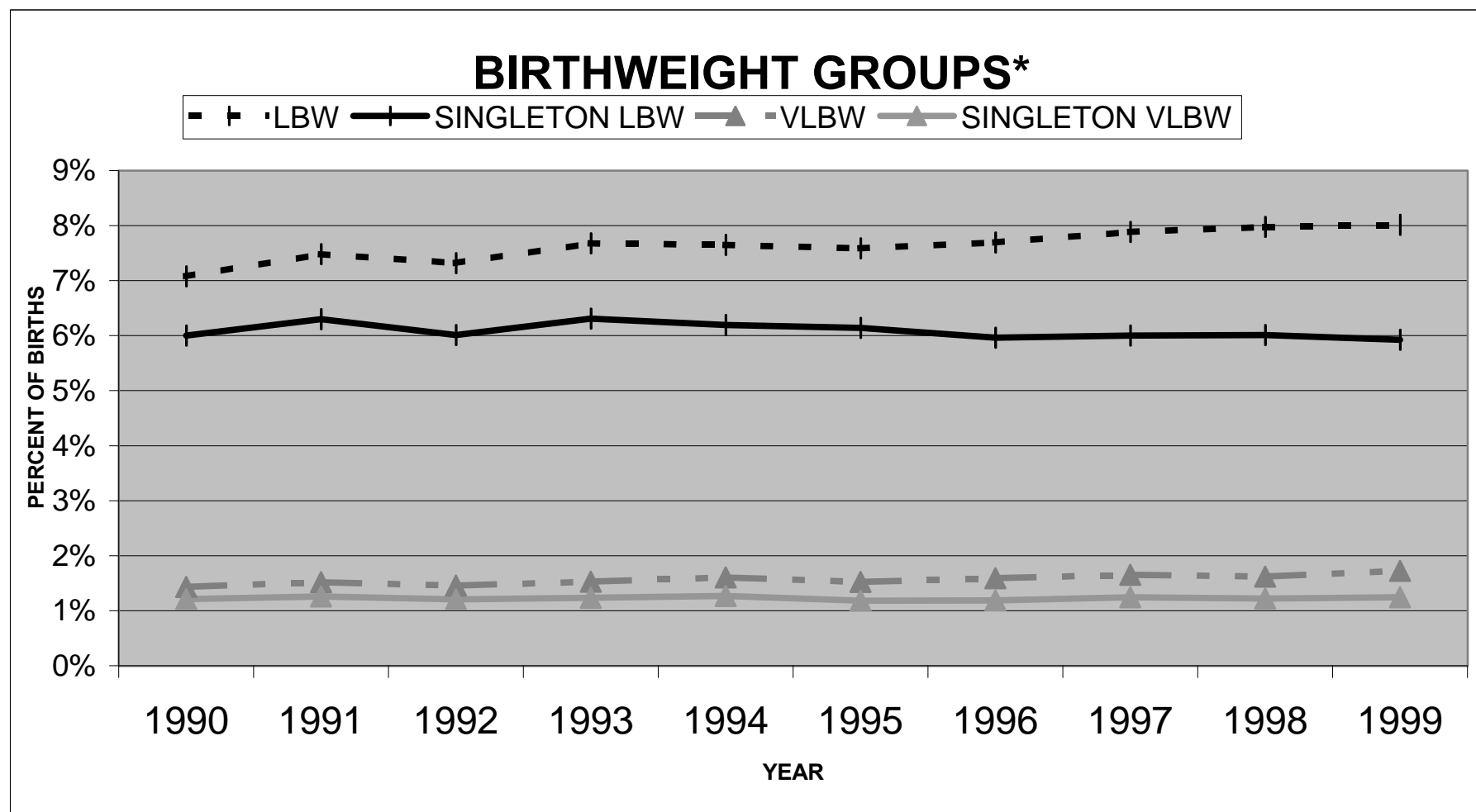


Source: NJDHSS Birth Certificate Files, as of 3/2000, New Jersey Residents

*Source of prenatal care recorded as None. Missing and unknown responses excluded from calculations

Race/ethnic groups - Hispanic regardless of race; white, Non-Hispanic; black, Non-Hispanic

1997, 1998 & 1999 data is provisional

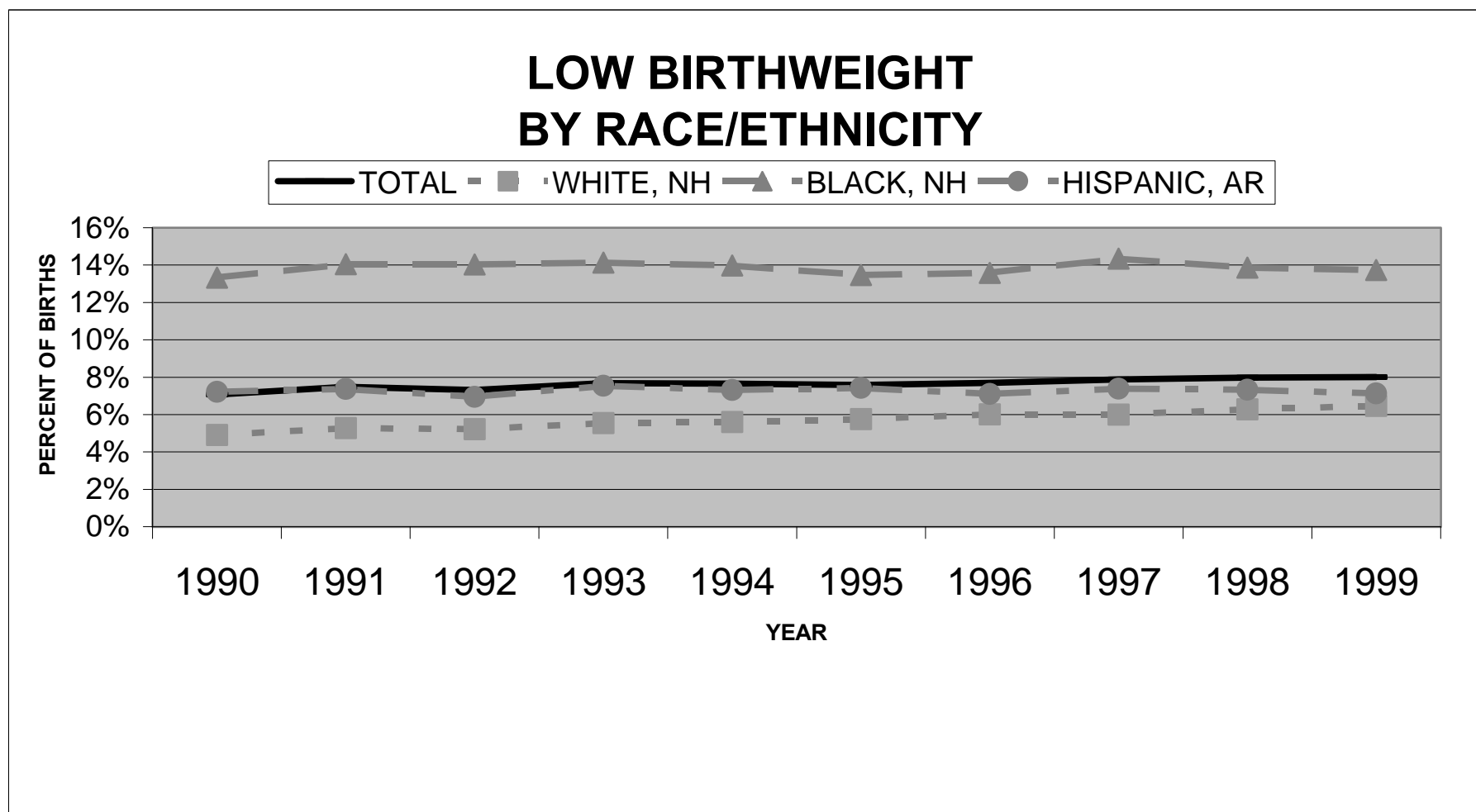


Source: NJDHSS Birth Certificate Files, as of 3/2000, New Jersey Residents

*LBW=birthweight <2500 grams, VLBW=birthweight <1500 grams, SLBW=singleton birth <2500 grams, SVLBW=singleton birth <1500 grams.

Missing and unknown responses excluded from calculation of rates

1997, 1998 & 1999 data is provisional



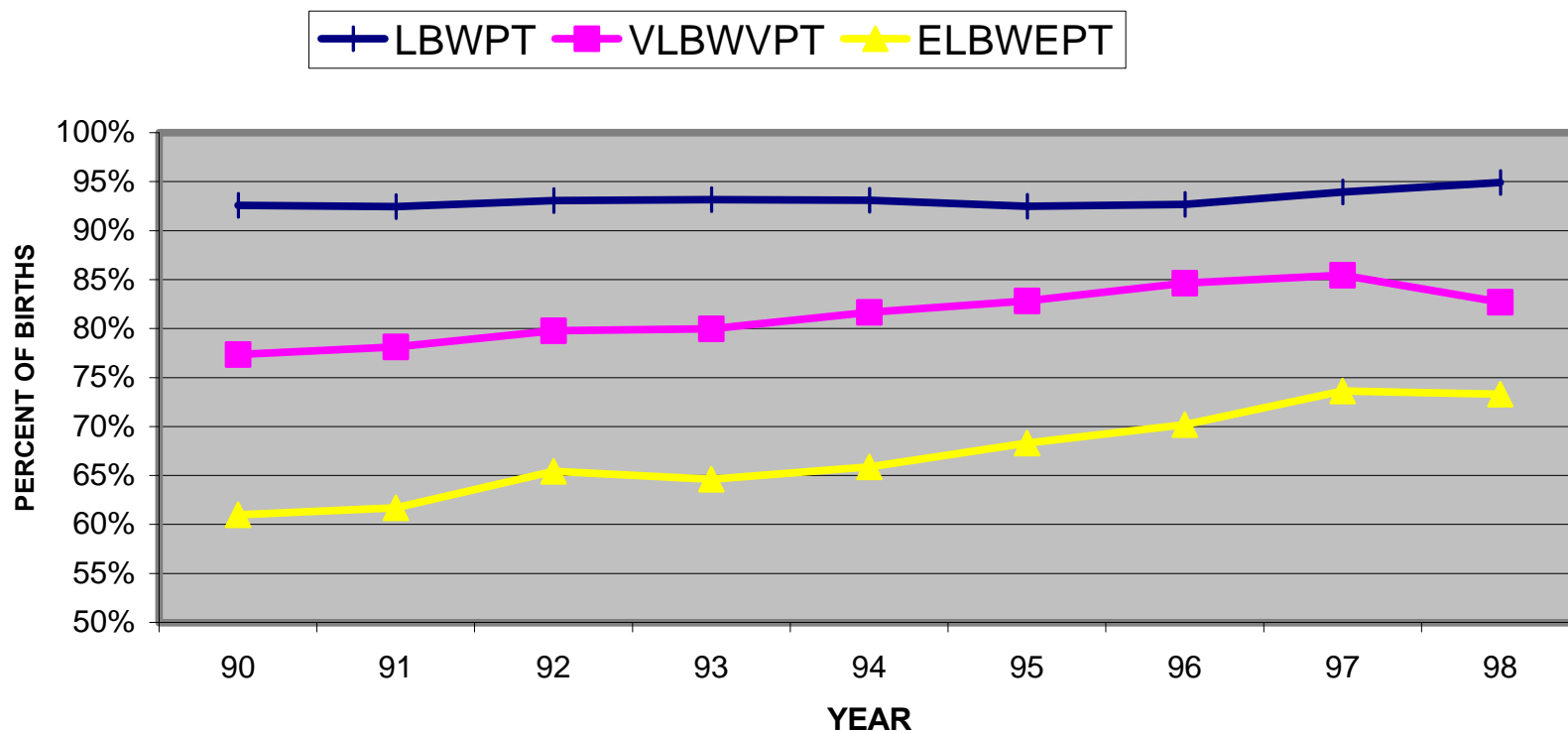
Source: NJDHSS Birth Certificate Files, as of 3/2000, New Jersey Residents

Low birthweight = birthweight <2500 grams. Missing and unknown responses excluded from calculations

Race/ethnic groups - Hispanic regardless of race; white, Non-Hispanic; black, Non-Hispanic

1997, 1998 & 1999 data is provisional

APPROPRIATE LEVEL OF DELIVERY ACCORDING TO PERINATAL GUIDELINES*

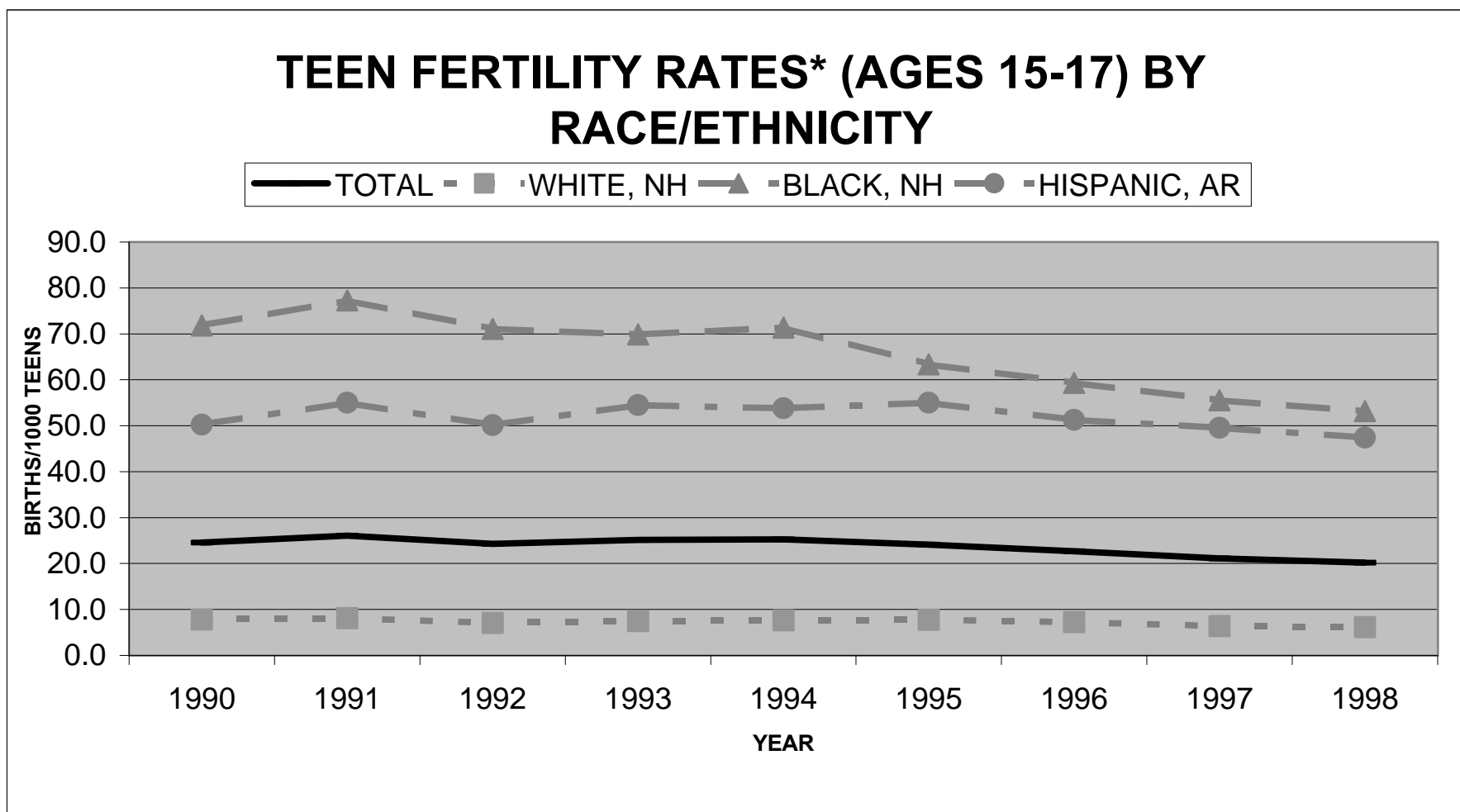


* Guidelines for appropriate level of delivery established by Perinatal and Hospital Licensing Standard regulations

LBWPT=birthweight <2500 grams or gestation <37 weeks, VLBWVPT=birthweight <1500 grams or gestation <32 weeks,

ELBWEPT= birthweight <1000 grams or gestation <28 weeks . Missing and unknown birthweights or gestations excluded

1997 & 1998 data is provisional

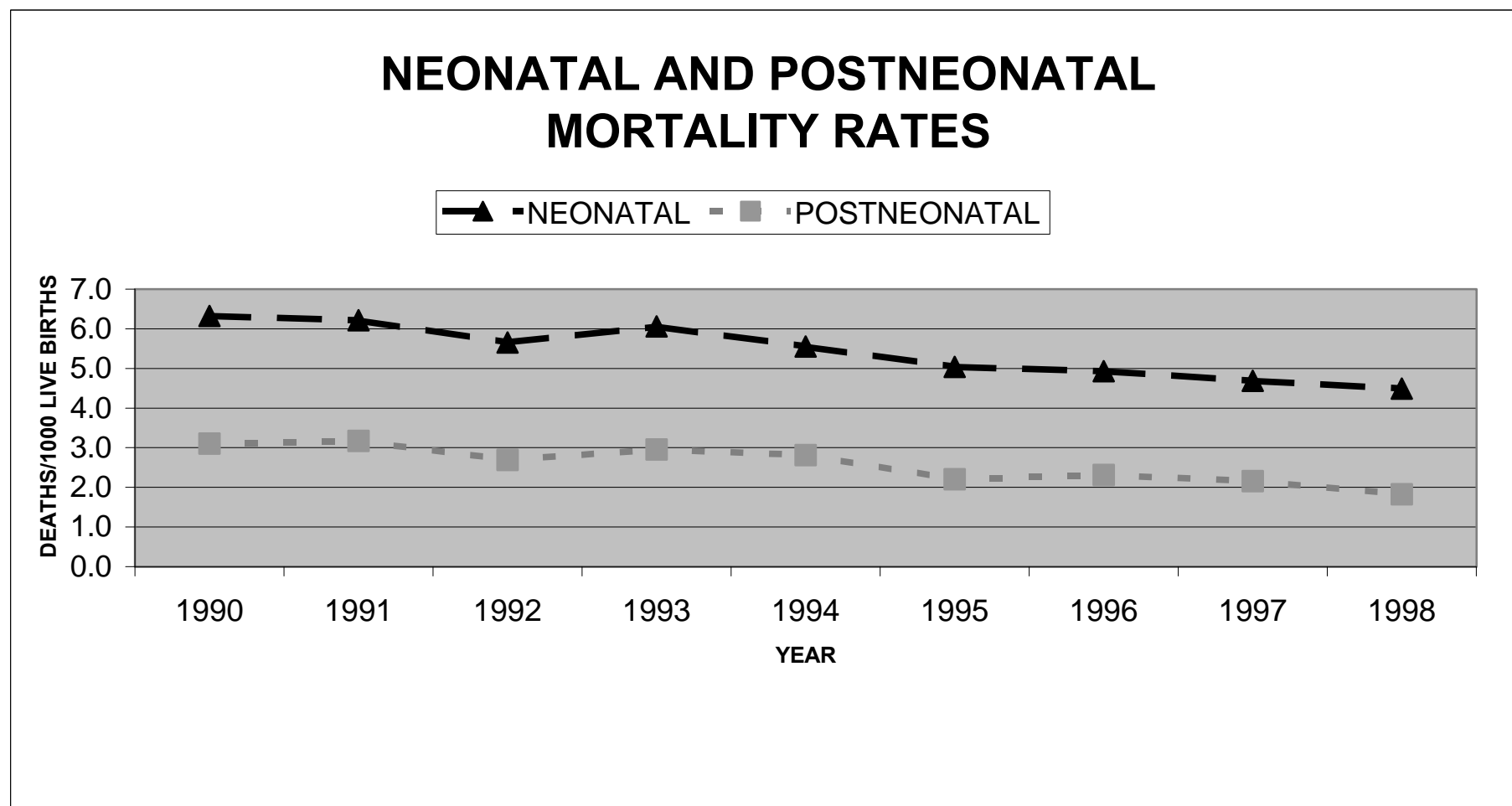


Source: NJDHSS Birth Certificate Files, as of 3/2000, New Jersey Residents

*Live births to mothers 15-17 years old per 1000 women in 15-17 year age group. Missing and unknown responses excluded from calculations

Race/ethnic groups - Hispanic regardless of race; white, Non-Hispanic; black, Non-Hispanic

1997 & 1998 data is provisional

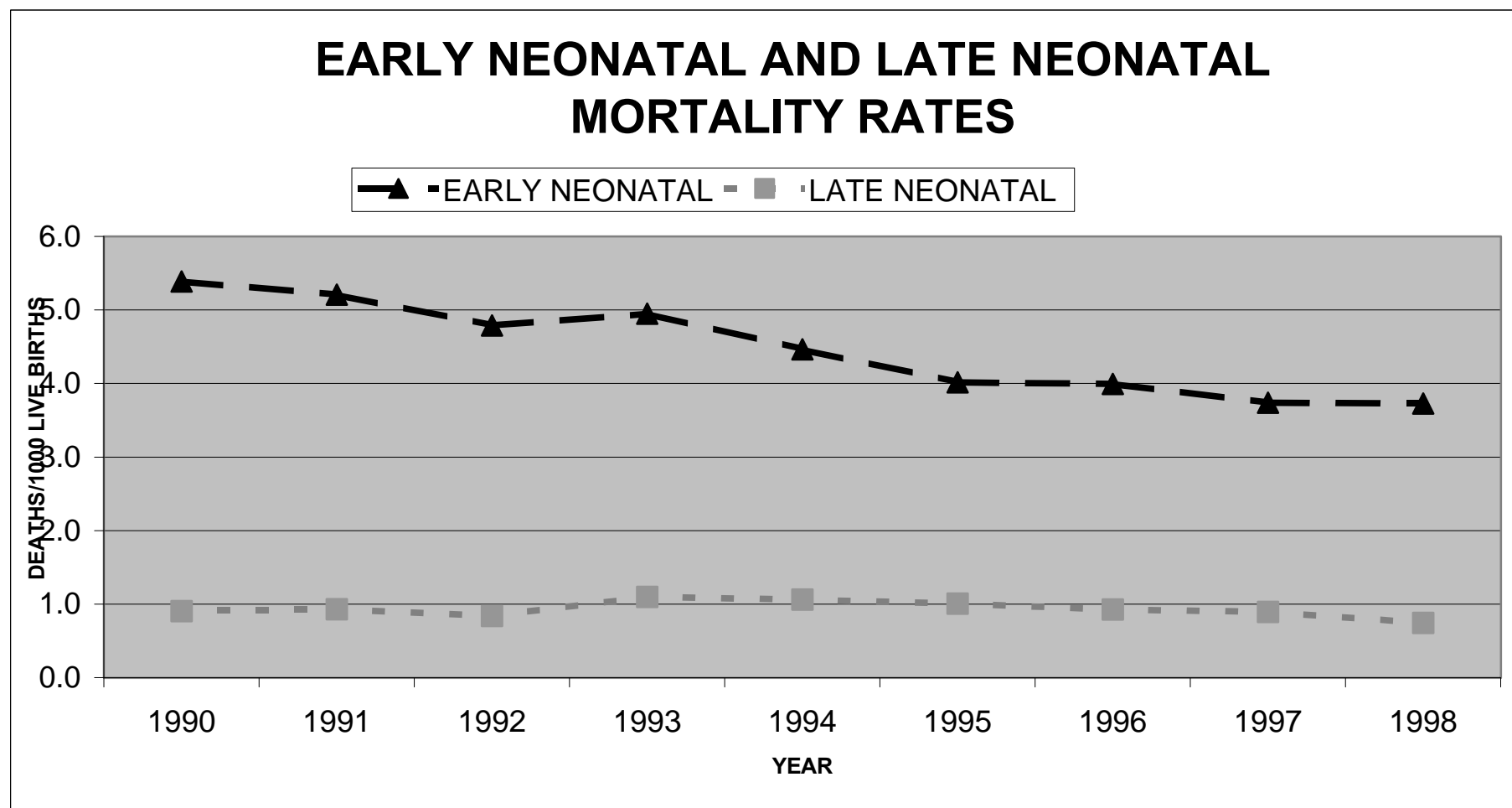


Source: Birth Certificate and Death Certificate files for New Jersey Residents

Mortality rates = number of deaths in the age group in the calendar year * 1000 divided by the number of live births in the same year

Neonatal deaths - occurring 0 - 27 days, Postneonatal deaths - occurring 28 - 364 days

1997 & 1998 data is Provisional



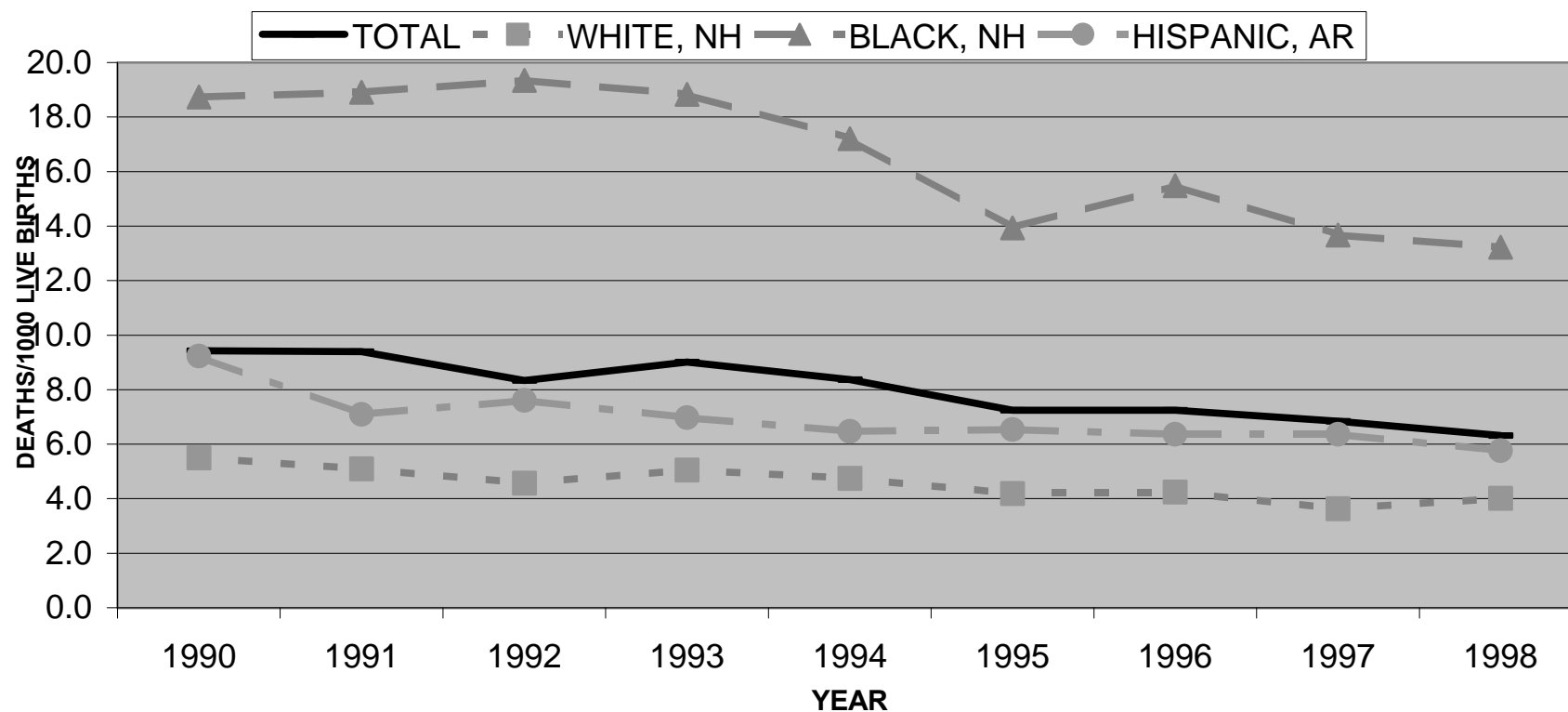
Source: Birth Certificate and Death Certificate files for New Jersey Residents

Mortality rates = number of deaths in the age group in the calendar year * 1000 divided by the number of live births in the same year

Early neonatal deaths - occurring 0 - 7 days, Late neonatal deaths - occurring 8 - 27 days

1997 & 1998 data is Provisional

INFANT MORTALITY RATES BY RACE/ETHNICITY

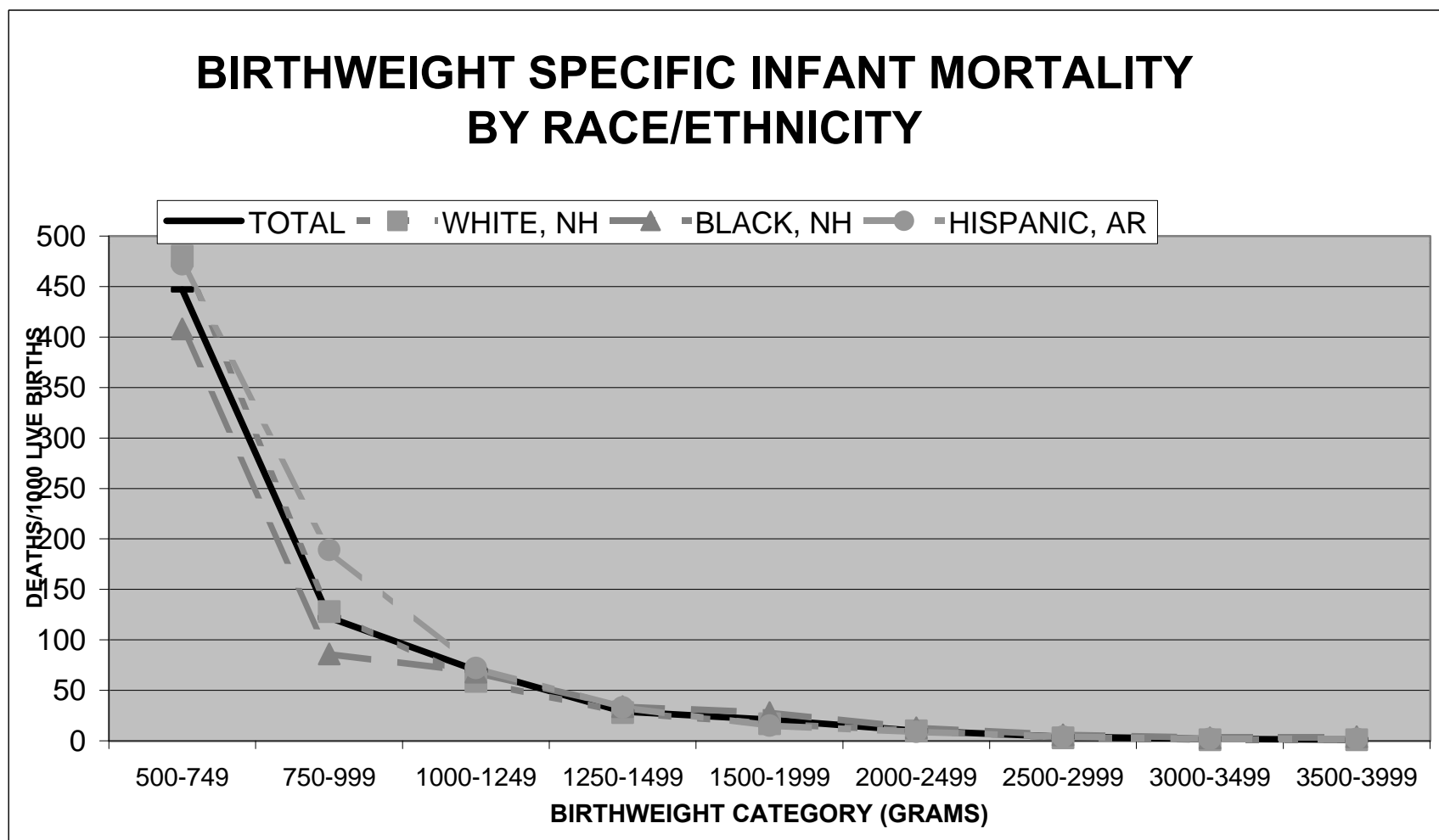


Source: Birth Certificate and Death Certificate files for New Jersey Residents

Mortality rates = number of deaths in the age group in the calendar year * 1000 divided by the number of live births in the same year

Race/ethnic groups - Hispanic regardless of race; white, Non-Hispanic; black, Non-Hispanic

1997 & 1998 data is Provisional



Source: Linked Birth Certificate and Death Certificate files for New Jersey Residents for 1996 and 1997 provisional data

Birthweight specific infant mortality rates = number of deaths in birthweight category * 1000 / number of live births in birthweight category

Race/ethnic groups - Hispanic regardless of race; white, Non-Hispanic; black, Non-Hispanic

PERIODS OF RISK APPROACH TO FETAL AND INFANT MORTALITY
1997 TOTAL DEATHS

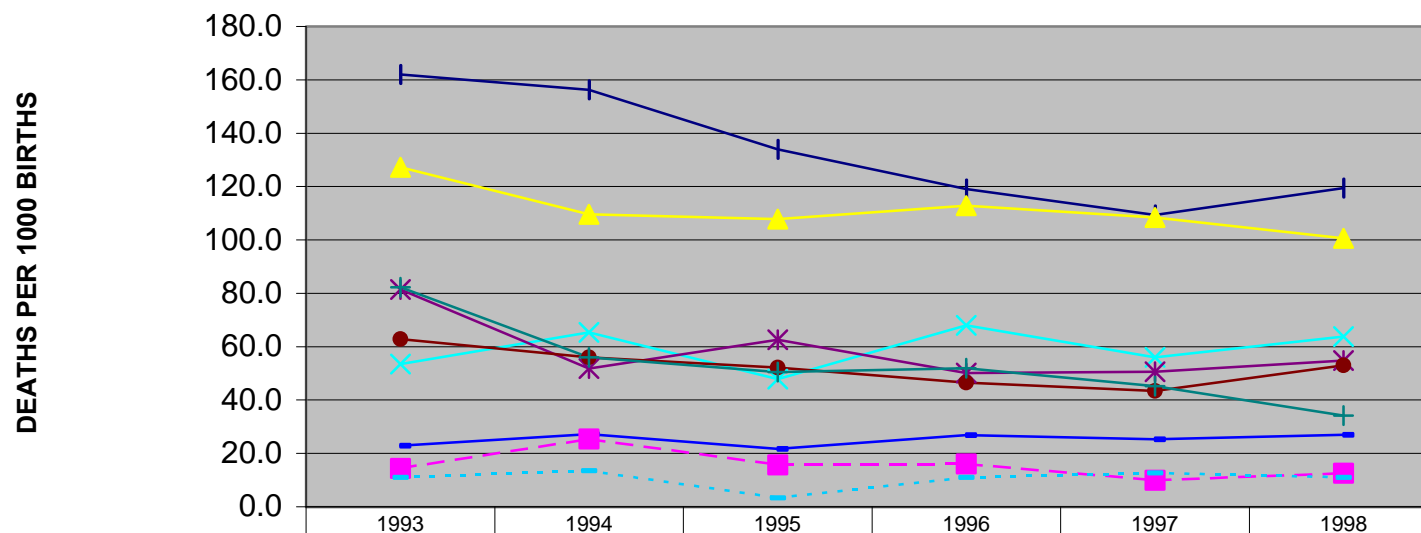
WEIGHT	FETAL DEATHS (>20WKS)	EARLY NEONATAL DEATHS	LATE NEONATAL DEATHS	POSTNEONATAL DEATHS	TOTAL DEATHS	BIRTHS
<1000 GRMS	378	307	30	32	747	945
1000-1499 GRMS	59	19	11	14	103	913
1500-2499 GRMS	82	28	17	39	166	6989
2500+ GRMS	132	46	31	108	317	103851
UNKNOWN	127	3	2	1	133	130
TOTAL	778	403	91	194	1466	112828

1997 WEIGHT & AGE SPECIFIC MORTALITY RATES

WEIGHT	FETAL DEATHS (>20WKS)	EARLY NEONATAL DEATHS	LATE NEONATAL DEATHS	POSTNEONATAL DEATHS	TOTAL DEATHS	BIRTHS
<1000 GRMS	285.7	324.9	31.7	33.9	747	945
1000-1499 GRMS	60.7	20.8	12.0	15.3	103	913
1500-2499 GRMS	11.6	4.0	2.4	5.6	166	6989
2500+ GRMS	1.3	0.4	0.3	1.0	317	103851
UNKNOWN	494.2	23.1	15.4	7.7	133	130
TOTAL	6.8	3.6	0.8	1.7	1466	112828

Source: Fetal Death files and Linked Birth Certificate and Death Certificate files for New Jersey Residents for 1997 provisional data
 Fetal deaths > 20 weeks gestation, Early neonatal deaths - occurring 0 - 7 days, Late neonatal deaths - occurring 8 - 27 days
 Postneonatal deaths - occurring 28 - 364 days

CAUSE OF INFANT DEATHS



ANOMALIES (740-759)	1993	1994	1995	1996	1997	1998
LBW (765)	127.3	109.6	107.8	112.8	108.4	100.6
MATERNAL (760-763)	53.4	65.4	47.8	68.0	56.0	63.8
RDS (769)	81.4	51.8	62.6	50.1	50.6	54.8
PERINATAL/RESP (770)	62.8	56.1	52.2	46.5	43.4	53.0
SIDS (798.0)	82.3	56.1	50.4	51.9	45.2	34.1
PERINATAL/INFECT (771)	22.9	27.2	21.7	26.9	25.3	26.9
INFECTIONS (1-41, 45-139, 320-323)	14.4	25.5	15.7	16.1	9.9	12.6
ACCIDENT	11.0	13.6	3.4	11.0	12.7	11.0

Source: NJDHSS Death Certificate Files, New Jersey Residents, provisional data for 1997 and 1998
Cause of death classified by ICD-9 coding (in parentheses) on death certificates

LEAD SCREENING TEST RESULTS REPORTED* TO NJDHSS
JULY - DECEMBER 1999 Verse JULY - DECEMBER 1998

Month In 1999	July	August	September	October	November	December	TOTAL
Report Type							
Non-elevated	9867	12519	13889	11800	10693	10001	68769
Elevated	284	342	340	223	187	119	1495
Total	10511	12861	14229	12023	10880	10120	70624

Month In 1998	July	August	September	October	November	December	TOTAL
Report Type							
Non-elevated	1033	1105	1341	1104	744	861	6188
Elevated	415	447	503	377	219	199	2160
Total	1448	1552	1844	1481	963	1060	8348

* Voluntary reporting

BIRTHS TO TEENS BY AGE GROUP, 1992-1996

AGE GROUP (YEARS)	1992	1993	1994	1995	1996
10 - 14	269	279	284	226	207
15 - 17	3446	3586	3688	3585	3410
18 - 19	5859	5470	5628	5512	5154
TOTAL	9574	9335	9600	9323	8771
% OF TOTAL	7.9%	7.9%	8.2%	8.1%	7.7%
TOTAL BIRTHS	120446	117841	117684	114935	114335

Source: NJ Center for Health Statistics. Birth Certificate data for New Jersey residents